Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene? 0.00 0.7001

		_	_ State	Maryland		rimeni of n			leg. No.	107	0 1 0 0 1
			Registrar 1. Decedent's Name (First, Middle, Last)		001	inoute of L		2. Date of Dea	th	Vaar	3. Time of Death
	Physicia /Medic		Richard Ivan M	yers, S	r.			Month March	Day 2	2009	4:15 P M
	Examin		4a. Facility Name (If not institution, give street and num	ber)		4b. City, Town, or	Location of Death			ty of Death	
, A			301 N. Main St.			New Win	ndsor If Under 24 Hrs.	0 Date of Birth		arroll	place (State or Foreign
	Funeral Director		214-36-8066 ^{1⊠ M 2□ F}	7. Age (In yrs. Ia	71 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct. 29	Year) 9,1937	Cour	yland
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	Maryl f sho	ŗ	Maryland Carroll			I.	Tew Winds	or			1⊠Yes 2□No
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	th with	al D	301 N. Main St.				776			U.S.	
	r dea	Funeral Director	Armed For		6. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,	
20	rs afte	by F	1 ☐ Never Married 2 【X Married I ☐ Yes If Yes, Giv Year or Da	e	1	∐Yes 2⊠No	Specify:		Spec	oify: Wh	ite
2-003e	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural"; or Items 23a or 28a-f show raumatic event, the Medical Evantings must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of work	ing	16b. Kind of	Business/In	dustry
7	vithin 7	mple	Elementary/Secondary (0-12) College (1	4or 5+)		oo NOT use retired er/operat			con	struc	tion
Z	iled w Hygie ther t		10 17. Father's Name (First, Middle, Last)		OWIR	er/Operac	18. Mother's Nam	e (First, Middle,			
and	ev d c	To Be	Ivan Wolfe Myers			ı		Mary 1	E. Hahi	n	
ary	shoul and M s mari umati	۲	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	er, City or Tov	vn, State, Zi	code)
Ž	and 2 ealth a eartra		Anna Mae Myers/ wife			. Box 29		Windsor,			
ore	ges 1 and 2 should tt of Health and Mer If Item 27 Is marke or other traumatic		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from 5	nate i		sition (Name of natory or other place		Date	20c. Locatio	n - City or To	own, State
E	t. Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify)	st.	Paul'	s Luth. (Cem. 3/6/	2009	Union		
n n	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau		21. Six at the influence Service Licensee Sars	Elen		Name and Address 10 Church		rtzier 1 New Wind			
			23a. Part1. Enter the disease, or complications that constructions that constructions are constructed by the construction of t	used the death				or respiratory as	rrest,		Approximate Interval Between
× 1	Physician		Immediate Cause (Final disease or condition	Tom Add	4. 8	mallo	000 les	CA		5	Onset and Death
j	/Medical		resulting in death)	or as a consequ			0				
	Examiner	_	Sequentially list conditions, b.	or de a consecu	sormo effe					-	
У	nsit	Examiner	cause. Enter Underlying Cause (Disease or Injury	or se a consecçu	JOHN CIT						
-	exect an and ial-tra	Exa	that initiated events c.	or as a consequ	uence of):		·	·			
98/PU	ificate be executed g physiclan and as the burial-transit	edical	d						.		
	2 2 4		IF FEMALE: 23c. If yes, out	come of pregna	incv		1101		224	Date of deli	
X R R	death certific e attending p id for use as 1	hysician/M	in the past 12 months?	irth 2 ☐ Fetal ant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		23u.	Date of deliver Month	Day Year
j.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown								
ις. Τ	w requires that the de s been signed by the should be detached	by P	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
ğ	equire sen si ould b	ted			-			1[34	Yes 2∐N		bably 4 🗆 Unknown
Vital Records,	The law rate has be	Completed						24a. Was autop		tb. Were aut prior to c death?	opsy findings available ompletion of cause of
<u>_</u>	sician: The law certificate has b irector, page 2 s							1 □ Yes	2 12 No		2/ HVo
=	sicia certi irecto	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	npatient 2 🗆	EB/Outpatie	nt 3 🗆 DOA Oth	er: 4 \ Nursing H	ome 5 Lesi	,	Other (Sne	nify)
Ö	iding Physician: th. : After this certifica funeral director, p	n: To	27. Manney f Death 28a. Date		28b. Time o		y at	28d. Describe		- ' '	
ĕ	endin rath. or: Aff	atio	2 Accident investigation			M 1□	Yes 2□No				
Division	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certification that the funeral director, to completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of Injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and No wn, State)	ımber or Ru	ral Route Number,
_	spital		29a. Certifier 1 Certifying Physician: To the	best of my kno	wledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) and	manner as	stated.
	ne Ho	Medical	(Check only 2 Medical Examiner: On the b	asis of examina ner stated.	ation and/or ir	vestigation, in my	opinion, death occu	irred at the time,	date and pla	ce, and due	to the cause(s)
	Vithi To to	Ž	29b. Signature and title of certifier	:		29c. Licens	se number		29d. Date si	gned (Month	n, Day, Year)
			Scorest A King	MON	M	1006	24597		5/	5/0/	
	6	(30/ Name and address of person who completed caus	e of death (Iten	n 23a) (Type,	Print)	LINKL	MADI	57	,	
	Sta	te	31. Date filed (Month, Day, Year) 32. F	egistrar's Signe	ature	T U (B)	HINSTER	11.00) -1		
	Registr		MAR 0 6 2009 Leny	m B.	par						

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otate of warylan		tificate of L			Reg. No.	009	0/002	
	Physicia	an	1. Decedent's Name (First, Middle, Las	(t)				Date of Dea Month	Day	Year	3. Time of Death	
	/Medic	al	Sime Mi	M7		4h City Town or	Location of Death	MARCH		009 ty of Death	4:00A [™]	
1	Examin	er	4a. Facility Name (If not institution, given STERLING ASSISTE			BALTI				N/A		
Ī	Funeral		5. Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp Coun		
	Director		220-05-9341 Just 1 Usual Residence of Decedent	[™] 2X ⁺ 90	115.			02/27/1	1919		MD	
	aryland show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits	
	e Mar Ba-f sl	ctor	MD BALTIN	10RE	BALT	IMORE			10g. Citizen o	f What Coun	1 ☐ Yes 2 ☐ No	
	with the	Funeral Director	10e. Street and Number 6527 GARDENWICK	ROAD		10f. Zip Code	1209		rog. Citizen o	USA	uy:	
	death ms 23	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Vas Decedent of H f Yes, specify Cuba		ecify Yes or No	- 14. R	ace - Americ lack, White, 6		
330	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Evaluation and once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 _Yes 2 No If Yes, Give Year or Dates:		Yes 2∭XNo	Specify:	, , , , , , , , , , , , , , , , , , , ,	Spec		WHITE	
2-003p	72 hou natura lical E	eted	15. Decedent's Ed (Specify only highest gra	lucation (de completed)	16a. Deced	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	ing	16b. Kind of	Business/Ind	lustry	
7	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		GR	OCERY					
Z Du	filed v Hygie other 1		17. Father's Name (First, Middle, Last,			OWNER	18. Mother's Nam	e (First, Middle,	Maiden Surn	ame)		
Ian	uld be Mental rrked c	To Be	NATHAN	FAGAN			ROSE		POLOVO			
lar)	2 should and Men is marke	ľ	19a. Informant's Name/Relationship (ng Address (Street						
e O	1 and 2 Health em 27 i		HOWARD MINTZ / S	50N 20b. F		GARDENWI sition (Name of natory or other place		BALTIMO Date	20c. Locatio			
бащшо	Pages ment of ant: If ite ury or o		1 Burial 2 □ Cremation 3 □ Cremation 3 □ Cremation 5 □ Other (Special Control of C	Hemoval from State MO	GAN ABF	RAHAM CON	G. 03/09	5/2009	ROSEDA	LE, M)	
Dall	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lice	nsee		2. Name and Addre	5(OL LEVIN	NSON & [KESVIL			
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat							Approximate Interval Between	
٠ مر	Physician		Immediate Cause (Final disease or condition	Myo cald	ial Is	Kasctio	<u> </u>				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):	. 04	end				10 2/15	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	juence of):	bod ove	2W		_		10 713	
	nd A land	Examiner	Ecque daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с								
8/60,	rificate be executed ng physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):							
280	+ 5.8	Medical	U. E. W. E	S U	507							
O. Box	death ce e attendi	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet: 4 Pregnant at time of 9 Unknown	al death 3	☐ Ectopic pregnand ☐ Other (specify) _	эy ————————————————————————————————————			Date of deliv Month	ery Day Year	
J.	requires that the veen signed by th hould be detache		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?	
rds	quires an sign uld be	ed by	Atzheimers	cenentia				1 🗆	Yes 2 No	o 3∏ Pro	bably 4 ☐ Unknown	
Records,	e law re has bee je 2 sho	Completed					<u></u>	24a. Was auto perfe		prior to co death?	opsy findings available ompletion of cause of	
Vital	sician: The law certificate has t irector, page 2 s	ပိ	25. Was case referred to medical				26. Place of Dea		one)	1 ☐ Yes	2 ∐ No	
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2] ER/Outpatie	III 3 LI DOA		lome 5 🔀 Res			ify)	
on of	ling P		27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Woi	ryat rk?]Yes 2 □ No	28d. Describe	how injury oc	curred		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determine	De Diace of Injury . At h	l nome, farm, st <i>ify)</i>		1100 = 2.10	28f. Location City or To	(Street and Nu wn, State)	ımber or Rur	al Route Number,	
ā	spital o		29a. Certifier 1 Certifying F	hysician: To the best of my kn	owledge, dea	th occurred at the t	ime, date and plac	e, and due to the	e cause(s) and	d manner as	stated.	
	the Ho hin 24 t the Fu npletely	Medical	one)	miner: On the basis of examinand manner stated.	ation and/or in			urred at the time	29d. Date sig			
	5 N N N	2	29b. Signature and title of certifier	~		29c, Licen	33974	4	3/2	109	, 20,	
	H		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print)	A A 1010	e Qui	+, Marc	M ₁	21709	
		ate	31. Date filed (Month, Day, Year)	37. Registrar's Sign	nature		, I land		1 11 10/4	1		
	Regist	rar	MAR 0 5 20	UJ KRAUL A	7. JAPA	1						

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		1 - For State Registrar	State of Marylai		artment of H			ene g. No.2009	07003		
/Me	sician edical miner	1. Decedent's Name (First, Middle, Roy Ecr 4a. Facility Name (If not institution,	No T	TINGI	4b. City, Town, or		2. Date of Death Month February	Day Year			
Funer Direct		212-44-8762		. last birthday) Yrs.	Baltino. If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birth Jan. Day	9. Bi	rthplace (State or Foreign Marry Land		
ne Maryland 8a-f ahow	ector		imore 10c. C	ity, Town or Lo		erstown		On Citizen of What C	10d. Inside City Limits 1 □ Yes 2 ☒No		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or other traumatic avent, The Medical Experiment intuitive multified at	Funeral Director	10e. Street and Number 11921 Tarragon I 11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in Agned Forces?	d 12. Was Decedent Ever in U.S. 13. Was Apped Forces? 13. Was			? (Specify Yes or No- uerto Rican, etc.)	10g. Citizen of What Country? United States o- 14. Race - American Indian, Black, White, etc.			
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mantal Hygiene. Sty is marked other then "natural", or reumatic avent, the Medical Evant	Completed by F	3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Specondary (0-12)	If Yes, Give Year or Dates:	16a. Dece (Give	dent's Usual Occup		working	6b. Kind of Busines Baltimor	Business/Industry imore Gas		
land 21.	To Be Com	17. Father's Name (First, Middle, L. Elmer Lee Nottin	ast)	Co1.	lection M	18. Mother's	Name (First, Middle, M		tric		
e, Mary 1 and 2 shou Health and N am 27 is mai		19a. Informant's Name/Relationshi Bonnie P. Nottii	ngham - Wife	1192 Place of Disp	ng Address (Street 21 Tarrage consistion (Name of pratox) or charge consistency of the constant of the constan	on Road	d, Reisters	City or Town, State, StOWN, MD	21136		
Baltimore, permit. Pages 1 ar Depertment of Hea Important: if item	once.	M Burial 2 ☐ Cremation 4 ☐ Donaljon 5 ☐ Other (Spot) 21 Stanlare of Free N Service M	Owings Mi eral Home butus, MD	,Inc.							
Physicia /Medic		est,	Approximate Interval Between Onset and Death								
te be executed Striction and Burial-transit	Je.	Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Brain stem herniation Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
VISION Of VITAL RECORDS, P.O. BOX 68/60, ~ ~ Attanding Physician: The law requires that the deeth certificate be executed refeath. each criticate has been signed by the eltending physician and by the ituneral director, page 2 should be delected for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown		23d. Date of d Month	lelivery Day Year						
PTGS, P. Oquires that the en signed by ould be detected.	ed by Ph	Part II. Other significant condition	s contributing to death but not re	esulting in the	underlying cause giv	en in Part I.			to the cause of death? Probably 4 Dunknown		
2 2 2	Ω	25. Was case referred to medical				26 Place o	24a. Was a autops perform 1 Yes 2	y prior t ned? death 2 No 1 □ Y			
Division of Vital Records, To the Hospital or Attanding Physician: The law requires I within 24 hours effer death. To the Furneral Director: After this certificate has been signer crompletaly filled in by the funeral director, page 2 should be completely filled in by the funeral director.	ation: To Be	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Injur	er: 4 □ Nurs	ing Home 5 Reside		pecify)		
DIVISION HOSPITAL OF Attail HOSPITAL OF ATTAIN THE PROPERTY OF THE PROPERTY OF THE PROPERTY FILLS FI	Certification:		building, etc. (Spe	cify)		City or Town	ocation (Street and Number or Rural Route Number, ity or Town, State)				
To the Hosp within 24 hou To the Fune	Medical	29a. Certifier (Check only one) Certifying Description (Check only one) Certifying Description Certifier Certifier Certifier	Physician: To the best of my k xaminer: On the basis of exami and manner stated.	nowledge, dea nation and/or i	nvestigation, in my o	pinion, death	occurred at the time, d	ate and place, and d	ue to the cause(s) onth, Day, Year)		
74	+	30. Name and address of person v	no completed cause of death (It		RES.	-000	D F	ebruary o	25, 2009		
	State jistrar	31. Date filed (Month, Day, Year)	Bydon, M.D. 32. Registrar's Sig	H94		n Aven	que Baltin	nove, M!	121224		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NORRIS **Physician** CBEVARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number (In yrs. last birthday) 1 □ M 2 212-74-0634 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Pres 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 2122 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 □No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Care trovider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) -lorine prose MOLLIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31318 Norri <u>eola</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) ugno C. Greene Fureral Services 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 montes disease or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): hy Physician/Medical Examiner a lical Certification To

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Examine must be maritimed.

Baltimore, Maryland 21215-0036

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fe	tal death 3 Ectopic pregnancy	2	'- 23d. Date of delivery Month Day Year				
Part II. Other significant conditio	ns contributing to death but not re	sulting in the underlying cause given in Part I.		se contribute to the cause of death?				
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No 9 Unknown 23d. Date of Injury 24d. Was an autopsy performed? 1 Yes 2 No 24d. Was an autop		24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No						
			eath (Check only one)					
	Hospital: 1 Inpatient 2[☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6	6 ☐ Other (Specify)				
1 Natural 5 Pending 2 Accident investig	(Month, Day, Year) ation	(Month, Day, Year) Injury Work?		y occurred				
dotorm	I 28e. Place of injury - At	home, farm, street, factory, office cify)	28f. Location (Street and City or Town, State,	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) Check only one) Check only one)	g Physician: To the best of my ke Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the time, date and planation and/or investigation, in my opinion, death oc	ace, and due to the cause(s) ccurred at the time, date and) and manner as stated. I place, and due to the cause(s)				
20h Signature and title of cortifier		29c. License number	29d. Dat	te signed (Month, Day, Year)				

State Registrar 29b. Signature

31. Date filed (Month, Day, Year) MAR 0 6 2009

and title of certifier



Baltimore, MD

09-01714 Stephen E. Payne

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2009 07005

,	1- For State Registrar	Certi	ficate of Death		Reg	g. No.	07 0700		
Physician	1. Decedent's Name (First, Middle,La				2. Date of Death Month	Day Year	3. Time of Death 0548 hrs		
ledical Examin	STEPH 4a. Facility Name (if not institution, gi	IEN E. PAYNE	4h City Town o	r Location of Death	February 2	8, 2009 4c. County of D			
	399 Old Stage Road Apt.		Glen Burni		RO, DE	Anne Arun			
Funeral	Social Security Number 6. S	ex 7. Age (In yrs. las			8. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or Foreign Country)		
Director	218-84-3796 15 Usual Residence of Decedent	M 2 F 4	Yrs. Months Da	ys Hours Min.	06/10,	/1968	Maryland		
au	10a. State 10b. County	10c. City, T	own or Location			,	10d. Inside City Limits		
SS Maryland 28a-f show d at once.	MD Anne	Arundel G1	en Burnie_				1 Yes 2 No		
Maryla 28a-f	MD Anne 10e. Street and Number		10f. Zip Code		10	g. Citizen of What	,		
with the Maryland in 23a or 28a-f she be notified at once		Road, Apt. B	3 2106		16 - V N-	U.S.A. 14. Race - American Indian, Black,			
death win the Maryland or items 23a or 28a-f sho	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	White, et			
ㅎ		1 Yes 2 No	1 Yes 2 ✓ N	o specify:		Specify:	White		
ours at atural	15. Decedent's Education (Specify	only highest grade completed)	6a. Decedent's Usual Occup during most of working life			16b. Kind of Busin			
6 n 72 hours an "natur ical Exam	Elementary/Secondary (0-12) 12 17. Esther's Name (First Middle Las	College (1-4 or 5+)					re City		
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E 2 - 2 = 1	Charlotte Tower	s/Mother	221 Furnac	e Road,	Glen :	Burnie,	MD 21061		
ore, Nes 1 and 2 of Health If item:	20a. Method of Disposition 1 Burial 2 Cremation 3	Pamoval from State Cr	ematory or other place)						
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Baltimo permit Page: Department o Importants injury or oth	21. Signature of Funeral Service Lice	nsee					al Home, PA MD 21122		
Physician	23a. Part I. Enter the disease, or com	plications that caused the death.	Do not enter the mode of dyin	g, such as cardiac c	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
/Me dical	failure. List only one cause on a	each line. . Narcotic (morp	hine) intoxio	ation			Death		
kaminer	or condition resulting in death)	Due to (or as a consequence of):							
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ecuted and - transit	events resulting in death) Last	,							
o, o, e be exect ysician an burial - tr	X UNPENDED IF FEMALE:	AMENDED 23a,27,2	28a-f, perME,	g889 3/9	/09 TT				
760, icate by physic the bus	22h Was decadent pregnant in the	23c. If yes, outcome of pregna				23d. Date of de	•		
Box 687 death certific	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of dea	2	Ectopic pregna	aricy	Month	Day Year		
BO)	2	9 Ulikilowii							
P.O.	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause	e given in Part I.			re to the cause of death? Probably 4 V Unknown		
IS, P.C quires that en signed			<u> </u>		1 24a. Was		re autopsy findings available		
cords, law requii	Completed					rmed? dea	or to completion of cause of ath?		
tal Rec			26 Pie	ice of Death (Check	1 Yes	2 No 1	Yes 2 No		
Vital ysician his certi director	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 DOA	Othor:	ng Home 5	Residence 6	Other: Scene		
ding Phy	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury 28c. In	njury at Work?	28d. Describe	how injury occurred			
ion tendin eath tor: A	Natural 5 Pending 2 Accident Investigs 3 Suicide 6 X Could not determin	E4 2/29/00 1	Fd 5:45 am	Yes 2 X No	unk				
Division of Vital Records, tal or Attending Physician: The law requirers after death. The law requirers after the certificate has been similar to be the former of the fo	2 Accident Investigation 2/26/09 Ft 3.43 attil 28f. Location (Street and Number or R or Town, State) 3/99 01d Apt B GLen Burnie								
hou hou	Loug Certifier	cian: To the best of my knowledg	e, death occurred at the time,	date and place, and	d due to the caus	se(s) and manner a	s stated.		
To the Hos within 24 h To the Fru completely	one) 2 Medical Examin	er:On the basis of examination an and manner stated.	d/or investigation, in my opini	on, death occurred	at the time, date	and place, and due	to the cause(s)		
	29b. Signature and title of certifier			nse number			(Month, Day, Year)		
	ullell			D.M.E.		February 28,	. 2008		
6 1	30. Name and address of person wh Ana Rubio MD. Assist		^{23a)} I 11 Penn Street, Balti r	more, MD 2120	11				
Sta	04 Data Statistics (4. D. of 6)	32. Legistrar's Signatur							
Regist	MARUOZ	1009 Levers 1	7. Barker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Petrovich 2009 R. 6:55p M Marjorie March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale Franklin Square Hospital 3irthplace Country) PA If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 S F 81 Director 165-20-9262 May 26,1927 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at White Marsh 1 ☐ Yes 2€ No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21162 11010 Birdriver Grove Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify.White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Lynn Raymond Chamberlain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. MD 11010 Birdriver Grove Road John Hunter son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State Rossville MD Gardens of Faith 3/6/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. 2 Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2 🗹 No the detached 9□Unknown law requires that the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate 2 PNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 DER/Outpatient 3 DOA 2 1 Inpatient this funeral 27. Manuar of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral To the h

> State Registrar

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

30. Name and address of person

Mon woods

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Year** Allen **Physician** Vallerson 08:16 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner N 5. Social Security Number 6 Chimont Saltimo Ku 0 F If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) f Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 2 M 2 □ F Days 215-76-5875 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location Od. Inside City Limits 10a State ns 23a or 28a-f show 1 ☑Yes 2 ☐ No Funeral Director Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ortant: If item 27 Is marked other than "natural", or items injury or other traumatic event, the Medical Examiner managed. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 □ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use, retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Labores 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pattersa Baltimore, Date 20c. Location City or Town, State 20a. Method of Disposition ㅎ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or once. Western 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) V4 HRS **Physician** ppen /Medical Due to (or as a consequence of): Examiner rophy sent Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; physician Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2 □ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4. Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 - No 1 🗆 Yes 2 DNo 1 □Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

31. Date filed (Month, Day, Year) State MAR 0 6 200 Registrar

29b Signature and title of certifier

ina

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

09-01761	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
Jerry Robert Pow	well State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death	700
Physicia	Registrar	eath
Medical Examin		s
	4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Accounty of Death Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Months Days Hours Min	or
Director	Usual Residence of Decedent Vrs. Months Days Hours Min. Nov. 16, 1945 Country) M.	1
d 10w any	10a. State 10b. County 10c. City, Town or Location 10d. Inside C	
I SPSE I hours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
the M	1 231 N. Calhoun St 21223 1 U.SA	
S with h with h with the no	11. Marital Status 1 Never Married 2 Married 2 No 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, B White, etc.	ack,
er deat	Never Married 2 Married 1 Yes 2 No specify: Specify: Specify: Specify: Plant Rican, Puerto Rican, Pu	
b hours after dunatural", or	or Dates 15 Decedant's Education (Chapting (C	
6 72 ho m "na cal Ex	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	/
5-0036 led within 72 Hygiene. other than	Elementary/Secondary (0-12) College (1-4 or 5+) To. Decedent's Education (Specify only highest glade completed) College (1-4 or 5+) House Keeping 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname)	<u>spital</u>
21215-00 uld be filed wit Mental Hygien marked other c event, the M	17. Father's Name (First, Middle, Last) Robert Powell Dorothy Henderson	•
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland to and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	19a, Informant's Name/Relationship (Type, Print) [Mctler] 19b. Mailing Address (Street and Number or Rural Route/Number, City or Town, State, Zip Code)	
ore, MD ss 1 and 2 sho of Health and If item 27 is ner traumati	Mrs. Dorothy Powell 2201 Walbrook Averzoi Balto Md. o	11216
	20a. Method of Disposition 1	,
Baltimore, permit Pages 1 a Departament of He Important: If it	4 Donation 5 Other Specify 11 11 11 11 11 11 11 11 11 11 11 11 11	<u>a. </u>
Balti permit Departn Importi injinry	21. Signature of Funeral Service Licensee 22. Name and Address of Recility 32. Name and Address of Recility 33. Funeral Home, P.A.	
Physician	23a Fart I. Enter the lisease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart litre. List only one cause on each line. Approximately the complex of the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart litre. List only one cause on each line.	
/Medical xaminer	Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease	ath
	or condition resulting in death) Due to (or as a consequence of):	
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· F.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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Box 68760, e death certificate he the attending physic ad for use as the bur	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown 2 Unknown 3 Unknown 3 Unknown 3 Unknown 4 Unknown 4 Unknown 4 Unknown 5 Unknown 5 Unknown 5 Unknown 6 Unknown 6 Unknown 6 Unknown 6 Unknown 6 Unknown 7 U	Year
th cert	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
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rds, require	24a. Was an autopsy finding prior to completion of death? 1 Ves 2 No 1 Ves 2	
of Vital Records, ng Physician: The law requir After this certificate has been suneral director, page 2 should	DE DESCRIPTION OF THE PROPERTY	No No
Vital Rec hysician: The l this certificate l	26. Place of Death (Check only one)	
Vit:	O 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA State And Nursing Home 5 Residence 6 V Other: Scene	
n of \ n ding Phy h After th	1. 27. Manner of Death 128a, Date of Injury 28b, Time of Injury 128c, Injury at Work? 28d, Describe how injury occurred	
Division tal or Attendir ss after death al Director: A	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Numb	mber, City
Division pital or Attent ours after death reral Director:	1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined Capacity (Specify) (Month, Day, Year) 1 Yes 2 No 2 1 Yes 2 No 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the 1		
To the Hos within 24 h To the Fin	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due	-1
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeal O.C.M.E. March 2, 2009	,
	30. Name and address of person who completed cause of death (Item 23a)	
Ψ	Ling Li MD Assistant Medical Examiner 111 Penn Street Baltimore MD 21201	
Sta Registr	tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 6 2009 Sentime 9. Search	
Negisti	PHAN PAGE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** M **Elizabeth Powell** 7:45a Feb 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore Rock Glen Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days Hours 1 M 2 F Director 219-41-0047 Mar 18, 1944 Maryland Usual Residence of Decedent with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1X Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or Items 23a or 2826 Windsor Avenue 21216 U.S.A Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify 3 Widowed 4 Divorced Black Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Fiscal Clerk 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Clark John Capers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Bailey 2826 Windsor Avenue Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 03/05/09 Baltimore, Md. Woodlawn Cemetery & Chapel Funeral Service Licensee 21. Signatura 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 not enter the mode of dying, such as cardiac or respiratory arrest, Enter the dis a se, or complice shock, or heart failure. List only on plications that caused the death D Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine as the burial-transit Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760 physician the attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1∐ Yes 21 or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Sing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 ☐ Accident 1 🗌 Yes 2 No 6 □ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my obtained and the control of the cause (s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 Joseph Franklin Pyles, Jr. 4:09 p M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9272 Old Scaggsville Road Howard Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) 1**∑** M 2□ F Months Days Hours Min. Country) 577-44-4720 76 **Director** Jan. 25,1933 DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2XXXNo MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9272 Old Scaggsville Road USA Funeral 20723 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Yes 2 Yes, Give 2□No1953-Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√√No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sign Manufacturing Co. than ' College (1,4or 5+) Elementary/Secondary (0-12) Owner d 2 should be filed w th and Mental Hygiei 7 is marked other th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Franklin Pyles, Sr. Constance Louise Ferguson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai Darlene A. Wade/ Daughter 6477 Grommet Drive, Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 7, Ft. Lincoln Cemetery Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. . Ken Stiles M01053 313 Talbott Ave., Laurel, MD 20707 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Cerebral Thrombosis minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day I ☐Yes 2 ☐ No 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Parkinson's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 2**X**No 2**X** No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat • Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only Medi To the 29b. Signature: 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

William A. Warren, MD,

31. Date filed (Month,

32. Registrar's Signature

321 Prince George St., Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g889 3-6-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day М Sidney Redmond 3/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner 4146 Windmill Circle Randallstown Baltimore Birthplace (State or Foreign Country)
 SC 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 02 30 th 1922 **X**□ M 2□ F 86 Months Days Hours Min. 247-24-5636 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hydiene. 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4146 Windmill Circle Funeral 211.33 12. Was Decedent Ever in U.S. Armed Forces?

1 Xi Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo 2 Specify: Specify: African-American 3 X Widowed 4 □ Divorced Year or Dates: 1942-1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Inspector</u> Bethiehen Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Henry Redmond ဂ္ Janie Bostick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. Yvette Jackson / Daughter 4146 Windmill Circle Randallstown, Maryland 21133 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 □ Buriat 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veteran 3/9/2009 Ovines Mills, Maryland 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Signaty/e neral Service Ligensee 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a 1 ☐Yes 2 ☐ No 9 Unknown been signed by should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò icate has been siç 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes □No 24a. Was an autopsy perform certificate 1 ☐ Yes 🛛 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Magner of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury ithin 24 hours after death.

the Funeral Director: A published in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AX address of person who completed cause of death (Item 23a) (Type, Print) v Street Ballimore MD21201 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

olan Matthew Rid	1	1- For State Certifical Registrar	ent of Health and Mental Hygiene ate of Death	Reg. No. 2009 0701								
Physician edical Examine	~	1. Decedent's Name (First, Middle,Last)	2. Date of D Month March 1	Day Year								
eulcai Examinic		Nolan Matthew Rice 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death								
		251 E Antietam Street	Hagerstown	Washington								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 1 X M 2 F	Months Dave Hours Min	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) IN								
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits								
<u>*</u>	_		South Bend	1 X Yes 2 No								
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?								
ith the Maryland 23a or 28a-f sho		1521 S. Scott Street	46613	United States								
after death with the Maryland al", or items 23a or 28a-f she liner must be notified at dace	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.								
fler de		3 Widowed 4 Divorced If Yes 2 X No If Yes 2	1 Yes 2 X No specify:	_{Specify:} White								
atura xamira	핡	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry								
36 n 72 h nan "n ical E	<u>ا</u> ۋ	Elementary/Secondary (0-12) College (1-4 or 5+)		Not Self Supporting								
5-0036 iled within 7/4 Hygiene to other than	Completed	0 17. Father's Name (First, Middle, Last)	Dependent 18. Mother's Name (First, Midd									
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2121; hould'be fill id Mental F is marked fite event, I	္	19a. Informant's Name/Relationship (Type, Print)	b. Mailing Address (Street and Number or Rural Route									
MD 3 shoulth and in 27 is animatic		\	521 S. Scott St., South Be									
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after Department of Itealth and Meridal Hygier Imporfant: If iten 27 is marked other than matural", injury or other transmatic event, the Medical Examiner.		1 Burial 2 X Cremation 3 X Removal from State crema	of Disposition (Name of cemetery, tory or other place) awn Cremation 03/05/2009	20c. Location - City or Town, State 9 South Bend, Indiana								
altin nit. P oartme oortan	ŀ	4 Donation 5 Other Specify: DOULTII 21. Signature of Juneral Seryin Licensee T. Harman	22. Name and Address of Facility Harman									
in in Der	1	23a. Part I. Enter the disease, or complications that caused the death. Do n	7221 Grayburn Drive, Glo	en Burnie, MD 21061								
Medical xaminer	failure. List only' one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
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ox 6876 ath certifica attending ph	sician/IV	23d. Date of delivery Month Day Year										
hat the ed by the detache	by Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the shaen, ing tables great and	oid tobacco use contribute to the cause of death?								
rds, Prequires t	ompleted t		24a. V	Yes 2 No 3 Probably 4 ✔ Unknown Vas an 24b. Were autopsy findings available prior to completion of cause of								
eco he Isw te has	티			erformed? death? les 2 No 1 ✓ Yes 2 No								
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Vita	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/C	Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other:								
of Vind Physical After this uneral dir	اڃا	(Month, Day,Year)		ribe how injury occurred								
sion trend death ctor: y the f	읉		3:30 pm 1 Yes 2 X No unk									
Division pital or Attent ours after death eral Director: filled in by the	ertification:	3 Suicide 6X Could not be determined (Specify) single fat	mily residence or Tov	on (Street and Number or Rural Route Number, City vn, State) 19850 Reidtown Rd Sstown, MD								
8 = = > \ \	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 ✓ Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and due to the	cause(s) and manner as stated.								
To To con	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
0		(anof Hallerin	O.C.M.E.	March 2, 2009								
_		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111) I Penn Street, Baltimore, MD 21201									
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Registr	_	WHIT O COOP CENSORS IN	parkel									
DHMH 17 Rev 1/200	01	OUNTE	RIGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Hygiene Certificate of Death Reg. No. 1 - State Registrar Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician February IHERINE 26 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SILVER MOWTODMER /
9 (Birthplace (State or Fireign
Country) SPRING FAIRLAND NURSING+ KEHAB (-IR 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** 1□ M 2 KF Months 7-28-221 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Exeminer must be notified at SILVER SPRINC ¥ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 8712 Colesville 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced Specify: permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVAN Moristown HS-12 CDEPAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RANK မ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) RVING ROACH 1 EXAS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HNAJOMY BYARN-23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate 3 use (Final disease or c ndition resulting in death) **Physician** CARDIORESPIRATORY TOUTE /Medical Due to (or as a consequence of): Examiner CHEMIC CARDIOMYOPA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burlal-transit law requires that the death certificate be executed CHRONIC Due to (or as a consequence of): P.O. Box 68760, Physician/Medical R DISEASE ORONAR IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ZYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ospital or Attending Physician: The law hours after death.

Lineral Director: After this certificate has I y filled in by the funeral director, page 2 s autopsy performe biventricular implantable 1 ☐ Yes 2. No 25 Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐Yes 2☐No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D63232 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD; 15225 SHADY GAOVE RD. # 208. MIGKVINE, MODINS50

Registrar

State

MAR 0 6 2009

PATRICIA 31. Date filed (Month, Day, Year)

S. GOMEZ

32. Registrar's Signature

amend #10b Per FH G889 3/06/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day andevander 21 09 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CAKLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1.2M 2□ F Months Days Hours Min. 3658-1010 Yrs Director WV Whitmer 3 Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational Experience of the modified at Garrett 10d. Inside City Limits DAKLAND Director 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ALDER Garrett 706 21550 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 27 No
If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Completed by Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mean Injury or other traumatic event, the Mean Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Timberman Woodsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boyd Vandevander Verdie Nancy Lambert Vandevander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5521 Westbrook Oaks Way - Spring, TX Robert Sherman - Nephew 77379 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 ☐ Other (Specify) 2-27-09 Franklin, WV 21. Signature of Furieral Salvice Licensee 22. Name and Address of Facility JC+ 2+5 42 4 18 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or conditior resulting in death) 5 EANS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physlcian: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physiciar IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate performed? of Vital 2 1 No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N006180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/20 3/1 Suite 1 oakland 8/6 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** A^{M} 4:00 March 2009 Norman Renninger Christian /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 15725 Germantown Rd. Germantown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 XM 2 F West Virginia 217-42-9917 65 July 6,1943 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County Show r than "natural", or items 23a or 28a-f shov 1 □Yes 2 X No Director MD Germantown Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 15725 Germantown Rd. 20874 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1965-70 Specify Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Financial services 5+ Investment wholesaler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fil ment of Health and Mental H ant: If item 27 is marked otl Betty Broadwater Julius Christian Renninger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20874 Anne Renninger - wife 15725 Germantown Rd., Germantown, MD other Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F.
Important: If itel
any Injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/5/2009 Sykesville, MD All County Cremation 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hartzler Funeral Home 21. Signature of Fundal Service Licenses atharine 404 S. Main St., Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e attending physician and d for use as the burial-transit law requires that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypercholesterolemia 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28b. Time of Injury Hospital or Attending Pl 24 hours after death. Funeral Director: After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 2, 2009 (UV) D0050209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Shen MD 501 Frederick Ave., Gaithersburg, MD 20877 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&19b Per Inf C889 3/25/09 III State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Victoria MARCH 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month), Day 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 580-10-0727 West Toolias Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural" or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notifited at 1 Yes 2 No THIRDORE **Funeral Director** 10e. Street and Number Elmer 10g. Citizen of What Country? 10f. Zin Code USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0.12) Battimore J. Academ (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's ို 19b. Mailing Address (Street and Myrector or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) of Health a Department of Hear 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 □Removal from State Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signature of Experial Service License Home 5240 Tu Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 HOUR Physician CARDAC ART ARRHOYMI disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Vonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Ves 2 No 1 Inpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

death with the Maryland

and 2 should be filed within 72 hours after

Maryland

Baltimore,

Records,

or Vital

To the Hospital or Attending within 24 hours after death.

ENT

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

HOSPITAL OF BALTIMERC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM 17, 20b per FH G889, 3/6/09 WS 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 574 **Physician** 1245 PM Earl Milton Swem 2009 /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Seasons Hospice 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth March Day Year) 916 7. Age (In yrs. last birthday 92 Yrs. 5. Social Security Number **Funeral** Days Min. Mary Tand 1 🗚 M 2 🗆 F 723-16-6576 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10h. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Medical Evantinat must be notified at 1 ☐ Yes 2 No Owings Mills Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21117 3315 Carroll Ave. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⅓Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ve filed within 7 all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Fence Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

George
Earl Swem permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Blanche Tawney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11609 Garrison Forest Rd. Owings Wills, MD. 21117 Nancy Wehner - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Grace U.M. Ch. Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Reisterstown, MD. March 8, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel F.A. 21, Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** K6na1 Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Tubular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Sepsis Physician/Medical IE EEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 Ø No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dorner Specify 1705 PICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5 # 2009

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State

2835 Smith Avenue Baltimore MD 21209 urtan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1445931

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death ecedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death ity Name (If not institution, give street and number) City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 📝 2 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f shov traumatic event, the Medical Examiner must be notified at 1 es 2 No Director TIMORE 10g. Citizen of What Country? 10f. Zip Code et and Numbe 9 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □ Yes 2 📉 o Specify. ≥ 3 Widowed 4 □ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) I be filed withir intal Hygiene. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evones. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt's Name/Relationship (Type. Print) ě ronic Place of Disposition cemetery, cremator Method of Disposition Burial 2 Cremaion 4 Donation 5 Other (Specify) Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signatu Funeral ervi Licensee MO155 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a ronsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Other: 4 Nursing Home 5 Residence Hospital: 6 Other (Specify) NOSPO 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Atural 5 Pending Division 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) CHARLE (MD 6701 N. Clyolo ST 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:07 AM February 26 Marie 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hillnder 24 Hrs Inion 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Director unknown Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 tes 2 □ No Funeral Director HMOLE 10g. Citizen of What Country? 10e. Street and Number 21213 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic access. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) hetc 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ೨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1404 N. Mont Ford Ase Baltimore MD 21213

Date 20c. Location - City or Town, State M 1/9169 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 3/6/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Nathe and Address of facility Vaugnon C. Greene Funeral Services 21. Signature of Funeral Service Licensee Vaudon C. Doone

4905 York Pd Baltmore

23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 Pork Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis week /Medical Due to (or as a consequence of): Examiner 41 Pan creatitis week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Mg/ Due to (or as a consequence of) Box 68760. attending physician Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4√ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Moushan-2009 AT 2438946 26 1-cloniary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISHRAQUE SUAWON, UNION M€ ISHRAQUE MEMORIAL HOSPITAL 32. Degistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 4.30 AM **Physician** BOSTON MAR SUMMERS 2009 03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOWARD GENERAL HOSPITAL COLUMBIA COUNTY HOWARD COUNTY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral ™**M 2□F Months 241-28-515 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location a or 28a-f show t be notified at 28a-f show 1 ¥Yes 2 □ No MD 13a1 timore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 prove 23a 50 plar **Examiner must** Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 "natural", or by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry the Medical most of working I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ass 6Th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F pe permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked any lijury or other traumatic evonce. Jum mers rida P 19b. Mailing Adress (Street and Number or Rura oute Number in, State, Zip Code) Informant's Name/Relationship (Type. Print 1501 toolar ove 20c. Location - City or Town, St. Owngs M:11s 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition .10.09 1 ■ Burial 2 Cremation 3 Removal from State garrison torest 4 Donation 5 Other (Specify) 21. Sig store of Funeral Tervice Licensee Greene 5151 Balto. Nat'I Pilce Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFECTION SEVERAL DAY URINARY TRACT Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760,~ Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of DIOVASCULAR DISEASE 24a. Was an autopsy perform death? 2 🗆 No 1 TYes PULMONARI To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificar completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOSDITALIST 00 D68002 2009 10 30. Name and address of person who complet dcause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA MD 21044 TIN M. OO, M.D. 5755

Registrar

State

31. Date filed (Month, Day, Year)

MAR 0 6 2009

Bene S. fores

32. Registrar's Signature

			1 = State Registrar		Cer	tificate of Death		Reg. No 2009 0/021				
	Physici: /Medic		1. Decedent's Name (First, Middle, La.	G Smith			2.	Date of Death Month March	Day	Year	3. Time of Death	
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or Location of Columbia	of Death		4c. County	of Death		
	Funeral		5. Social Security Number 6. S			If Under 1 Year If Under 3	24 Hrs. 8. Min.	Date of Birth			CUNTY place (State or Foreign of try)	
	Director		Usual Residence of Decedent	- H	Yrs.		1	(Month, Day,	937		MD	
	72 nours aner oean wirn me inaryand 'natural', or items 23a or 28a-f show diesi Evaninar nust be notified at	io	10a. State 10b. County	10c. City, To	cot					1	0d. Inside City Limits 1 ☐ Yes 2 💯 No	
•	or 28a-	Funeral Director	10e. Street and Number	1.1 1.1	1	10f. Zip Code)	10	g. Citizen of	_	ntry?	
:	ms 23a	neral	3125 Wheator	12. Was Decedent Ever in U.S.	13. W	/as Decedent of Hispanic Orig Yes, specify Cuban, Mexican	gin? (Specif	y Yes or No-	14. Rac		can Indian,	
0000	within 72 nouts after death with the Marylar ene. Than "natural", or items 23a or 28a-f show he Modical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		Yes 2 No Specify:	i, Paerio Nic	an, etc.)	Specif	ck, White,	ack	
	"natura	leted	15. Decedent's Ec (Specify only highest gra	ducation 16 ade completed)	(Giye k	ent's Usual Occupation	t of working	- 1	6b. Kind of B	usiness/In	dustry	
717	med within Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		use Wife			Do	me.	stic	
מום	ges i and z should be filed within 7z no tof Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last)	1 1		18. Mothe	1	First, Middle, M NCL '	aiden Surnar Dod	•		
Mary	h and M r is mar raumat		rsa. Informant's Name/Relationship (Type Print)	9b. Mailing	Address (Street and Nymite	er or Rural A		City or Town	State, Zip		
	of Health fitem 27 rother to		20a. Method of Disposition	Husband) 3	of Dispos	ition (Name of addy or other place)	Date		Oc. Location	City or To	hy MD 2104.	
	rtmer rtant:		1 ☐ Burial 2 ★Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(y) Gre	en l	Vlount 3	<u>3.6.</u>	09 [Balti	mor	e, driv	
0	Depe Impo any Ir		21. Signature of Funeral Service Licer	T. Greene	5	Name and Address of Pacility SIBULTON	Gree	ne fi Pille	(212)	LO 29)	enices	
			23a. Part 1. Enter the disease, or com shock, or heart fall re. List only Immediate Cause (Final		o not ente	r the mode of dying, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	a. Covovay a Due to (or as a construence	e of):	y disease				-	10 years	
E	xaminer	ē	Sequentially list conditions, if any, leading to immediate	b. Lud Style Due to (of as a consequence	yev	ral disease)				Syeans	
/ 1	nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c COPD							10 years	
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00 4	ling phy e as the	/Medical	IF FEMALE:	.							-	
	the attence	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			1	ite of delive onth	ery Day Year	
, 1	ned by e detacl		Part II. Other significant conditions of	ontributing to death but not resulting	g in the un	derlying cause given in Part I.		23e. Did tob	acco use con	tribute to ti	ne cause of death?	
scolds,	been sig	sted b	- Hypertension	<u></u>				1 ☐ Ye	2 □ No	3 Prot	pably 4 🗌 Unknown	
משבו הקר	ate has bege 2 s	Completed by			<u></u>			24a. Was an autopsy perform 1 □ Yes 2	ęd?	Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of	
VICAL	certifica ector, p	BeC	25. Was case referred to medical examiner?	Hospital:	-		·-	Check only one)			
5	er this	n: To	1 ☐ Yes 2 🔼 No 27. Manger of Death	28a. Date of Injury 28b	. Time of	3 DOA Other: 4 Nu 28c. Injury at Work?		5 Resider			(y)	
	leath. Ior: Aft the fun	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	M 1 □Yes 2 □I	No					
ביים מיים מיים	s after o	Certification: To	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	28f.	Location (Str. City or Town,	eet and Numi State)	per or Rura	al Route Number,	
Hoonie	within 54 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, pege 2 should be detached for u	edical (29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date an estigation, in my opinion, dea	nd place, and th occurred	d due to the ca at the time, da	use(s) and m te and place,	anner as s	stated. the cause(s)	
Š	Vithin To the compl	Me	29b. Signature and title of certifier			29c. License number		29	d. Date signe	d (Month,	Day, Year)	
	,		▶ USrumiento 1			D0064=			Mar	2,2	-009	
	\		30. Name and address of person who Latuken Sark	completed cause of death (Item 23a Miento MD 57	a) (Type, P 55	cedar lane	Colux	ubia, 1	11) 2	1044		
	Sta Registr		30. Name and address of person who Lattileen Sarv 31. Date filed (Month, Day, Year) #AR 0 6 200	32 Registrar's Signature	par	Ne la						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G889 3/13/09 Jh
State of Maryland Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 3, 2009 2:20 A M Parrish Spring Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3211 Wake Drive Kensington Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jul. 4, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2阡F 90 Yrs. Director 528-14-7611 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f ehow any injury or other traumatic event, Tra Medical Examinar must be notified at 905s. 1 ☐ Yes 25tho Director MD Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3211 Wake Drive USA 20895 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 4 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph A. Parrish 2 Ida Cook 19b. Mailing Address (Street and Number or Ryral Bouta Number, City or Town, State, Zip Code) 4854 Campanial Brive San Diego, CA 92115 19a. Informant's Name/Relationship (Type, Print) Paul Spring (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bountiful 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3-7-2009 4 ☐ Donation 6 ☐ Other (Specify) Bountiful, UT Cemetery 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Russon Brothers Funeral Home 295 North Main Street, Bountiful, UT um 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 1 Hour /Medical Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ettending physicien for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2 No certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \text{\overline{M}} Residence 6 \text{Other} Other (Specify) 1 ☐ Yes 2 No Certification: To this I Director: After this d in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[And the course of the cause of 29a. Ceptilier Medicai and manner stated. 29b. Sig title of certifier 29c. License number 29d. Date signed (Month, Day, Year) natur D25085 March 5, 2009 and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Ave., Silver Spring, MD 20902 Penny L. Bisk, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature

DHMH 17 Rev 1/2001

State

MAR 0 6 2009

Registrar

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, perMD, 8889 3/13/09 TT State of Maryland Department of Health and Mental Hygien 2009 Certificate of Death Reg. No. 2. Date of Death Day 27 Year SEBRUARY 17, 2009 11:25 PM 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ELLEN SKARDA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BEL AIR HARFORD UPPER CHESAPEAKE HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 ☐ **X** 90 Yrs. 214-03-7729 7-26-1918 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits worde ! 10a. State 10b. County r than "naturel", or iteme 23a or 28a-f ehov the Medical Expendent must be notified at 1 ☐ Yes 2 XNo **ESSEX** MD BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8620 KELSO DRIVE APT. A112 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6 other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth eny liquy or other treumatic event 908! 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES ELGERT **JENNY** (FOOS) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 EVELYN SNYDER/DAUGHTER 1310 GUNPOWDER CROSSING LANE MIDDLE RIVER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 3-3-09 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Div to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending

Skarda, Ellen M80050508U

32/24/2009

within 24 hours effer To the Funeral Dira completely State

death.

Diract filled in by

inno Mikityanskaya 500 Upper Chesopeake Drive Bel 31. Date filed (Month, Day, Year) MAR 0 6 2009 Registrar

2 Accident

3 Suicide

29a. Certifie

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

investigation 6 Could not be determined

しれし

30. Name and address of person who comp cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 05 5:50 AM Robert Stanley March 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ragicer Medical Center Baltimore Hopkins John 5 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1⊠M 2□F 217-38-6060 67 5-9-1941 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show traumatic event, the Medical Examinact rust be notified at 1 X Yes 2 □ No Dundalk Director MD Baltimore 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA 21222 6 Leeway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 The If Yes, Give Year or Dates: 1 □ Never Married 2 □ X arried 1 ☐ Yes 2 No. White Saltimore, Maryland 21215-0036 ö Specify: Specify: 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Window Installer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dolores Boddice James Stanley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traumonce. Dundalk, Maryland 21222 Darlene Stanley- Wife Leeway, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 3-9-09 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signature of Furneral Service Licensee Bradley-Ashton Funeral Home TEXICILA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2134 Willow Spring Road, Approximate Interval Between Onset and Death Immediate Cause (Final 24 hours Shock Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** hours bowel ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> 2 **N**O 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 🗐 0 Certification: To 28d. Describe how injury occurred 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

Hopkins

29d. Date signed (Month, Day, Year)

30. Tame address of person who completed cause of death (Item 23a) (Type, Print)

w Medical Center, 4940 Eastern Avenue, Maryland 2/22

Daming Johns (Month, Day, Year)

32. Registrar's Signature MAR 0 6 2009

and manner stated.

Medical Doctor

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 200^{Yea} 4, 7:30^A M **Physician** Dorothy Ann Stogdill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5408 Grindon Avenue Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Hours Days Min. 1 □ M 2 🗷 F 307-28-6317 79 April 3, 1929 Seymour, Indiana Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Molical Examiner must be notified at 1 X Yes 2 □ No MD Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 U.S.A. 5408 Grindon Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 🗷 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Northrop Grumman and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engine er 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental L.
Important: if item 27 is marrany injury or other 2 Be Gertrude Kruwell Frank Price ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5807 Pine Hill Dr. White Marsh, MD 21162 Tracey Cogar/Granddaughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03/09/09 1 ☐ Burial 2 ☐ Cremation 3 🌠 Removal from State Seymour, Indiana Riverview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 880 O Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac /Medical Due to (or as a consequence of): **Examiner** rdio Vascerla Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed erebrovasc the burial-tran Due to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 □Yes 2 🗓 No ģ 5 Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 2 □ No certificate 1 TYes After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\text{Nursing Home} \) 15 \(\text{\overline{M}} \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes 21 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? **Hospital or Attending** 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death.
neral Director: Af 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21234 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 0350 CHARLES DANIEL SNYDER, SR. 28 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, Year)
March 30, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days Hours 1930 78 Maryland Director 220-26-4942 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State al", or items 23a or 28a-f shov 1 ☐ Yes ※ No Hagerstown MD Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 220 may injury or other fraumatic event. The Management of the page 1000. 1252 Frederick Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXXes 2 □ No If Yes, Give Year or Dates: Kore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXNo Specify: Specify: þ, White Korea 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Service Station Grade 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexenia Marlow Daniel L. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hagerstown, Maryland 21740 1252 Frederick Street Doris V. Snyder Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Union Cemetery 03/07/2009 Burtonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 20707 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 4 POX Sequentially list conditions, acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed CACHESTA Due to (or as a consequence of) ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, HRONIP Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Hinknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Who 24a, Was an has certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Proposed or Attending Proposed States of Proposed Propose After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my original death. within 24 hours a To the Funeral I 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIEW DR ARBECTOWN

State Registrar

31. Date filed (Month, Day,

Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 07028 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 200[°]6° FRANCIS JOSEPH SCHULTZ 12:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 4,1920 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Months Days Hours Min. 217-09-5200 87 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens, i.e. invars are useau with the viatyla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If the Medical Examination in any once. Director 1 ☐ Yes 2√ No MD BALTIMORE FULLERTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 25 SIPPLE AVE 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify δ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ${ t MACHINIST}$ <u>MANUFACTURING</u> Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYMOND SCHULTZ MARY NOVAK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS SCHULTZ-SON 25 SIPPLE AVE BALTIMORE, MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 3/6/09 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC MO. BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part . Enter the diseashout, or leart failure r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No Division of Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifier (Check only one X Nurse Practitione To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely within 2. 29b. Signature and title of certifier 29c. License number 29d. Date-signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MARCH

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

MAR 0 6 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Landon Buchanan Smith, Jr. 28, February 2009 11:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sep. 12, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 76 Director 1932 Maryland 231-34-7880 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evanting. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 □Yes XX No Director Maryland Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 2058 Misty Meadow Road 21048 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 □ Yes 2XXNo If Yes, Give Year or Dates: Specify þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland State School Elementary/Secondary (0-12) College (1-4or 5+) for the Deaf Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Landon Buchanan Smith, Sr. Bernice Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Smith-Bell (Daughter) 2058 Misty Meadow Road, Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest
Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date **Burial 2 Cremation 3 Removal from State March 6, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Owings Mills, Maryland Signer of Full of Service License Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 nt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and pipetery filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 2 - No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes investigation 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westmin toner 31. Date filed (Month, Day, Year) State MAR 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4,2009 1:30 March J. Sakowski <u>Stanley</u> /Medical 4c. County of Death a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City FutureCare-Canton Harbor If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 217-03-0709 Yrs. Maryland Apr 2, 1919 Director 89 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinat must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐Yes 2 ☐ No Baltimore City Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 U.S.A. 802 South Kenwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Q Q 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter (unk) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Wisniewski 2 19a. Informant's Name/Relationship (Type. Print) Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 Green Acre Road Towson, Md. 21286 Shirley Kozlakowski 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem 2-9-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee FOT 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician erebrovascular Accident /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of) Mas Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No After this certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

MAR 0 6 2009 Registrar

ONE) DCRNP

ah, crop

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Revoterstown, 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

K125808

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 6:30 PM /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Baltimore Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 12-580 1 M M 2 □ F Months Director Usual Residence of Decedent death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, it a Medical Examinat must be notified at MARYLAND Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Çuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any liury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. MetMod of Disposition 1 M Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or lear t failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure Decompensated
Due to (or as a consequence of): /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine foot Raht attending physician and for use as the burial-tran 10 Due to (tras a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy Failure 205 2 X No 1 □ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the Funeral Directory filled in by the within 2 To the 1

422

Baltimore, Maryland 21215-0036

completely

State

31. Date filed (Month, Day, Year) MAR 0 6 2009

29b. Signature and title of certifier

29a, Certifier

(Check only one)

good Samaritan Hospital ,5601 32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 1/2001

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AMIR

Lock Raven

- 000

KA2027

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep		lental Hygien	ne	
		Tiegratia:	rtificate of Death	Reg. N	10.2009	07032
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Medic		Paul Unger			7 09	87 AM
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death	
-V		Drintenuggists	Sykesville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carall	Nano (Ctoto or Foreign
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 25 F 89 Yrs.	Months Days Hours Min.	(Month, Day, Yea	er) 9. Birting	place (State or Foreign MD)
Director	Ŭ.	Usual Residence of Decedent		1-10-50		TID
yłand sow at		10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
Mar a-f sh ified	ito	MD Carroll Sykesvi	11e			1 ☐ Yes ŽŽŽNo
th the or 28	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?
th wii		5841 White Rock Rd.	21784		Ţ	JSA
r dea	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene. show and "natural"; or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	1+0
5-0036 72 hours af 'natural', or dical Exam	d be		edent's Usual Occupation	16h	Kind of Business/In	
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2121; sd within 7 ygiene. ier than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	visor, Food Servic		ringfield	State Hosp.
Ind 21215-0036 be filed within 72 hours after death with the Marylar tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	en Surname)	
arylance should be and Mental is marked or umatic eve	To B	Brady Unger	Effie M	l. Hassinge	er	
		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Rur	al Route Number, City	y or Town, State, Zip	Code)
			1 White Rock Rd.,			
		11 I Burtal 2 Ni Cremation 31 I Bernoval from State 1	ematory or other place)		Location - City or To	
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Baltimo permit. Page Department o Important: If any Injury or	5 (4	21. Signature Briefer Service Licens 1	urrier-Queen ^{ac} ifuner 212 W. Old Liberty	al Home & Rd., Wint	Crematory field, MD	y, P.A. 21784
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Physician	X 16	Immediate Cause (Final disease or condition	I onoceette La	elder	1	Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):				
Examiner		Sequentially list conditions, b.				
V be is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
xecut and Il-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
I Records, P.O. Box 68760,— The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical E					
687 ificate g phys		d				
Box 6	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	-		23d. Date of delive	ery
death death defor	icia	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No.	□Ectopic pregnancy □ Other (specify)		Month	Day Year
ds, P.O. I uires that the de signed by the a id be detached f	hys	9 ☐ Unknown				
S, F	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	o use contribute to t	. /
cord w require been si				1 ☐ Yes	2 No 3 Prot	pably 4 Dunknown
Records, ne law requires the has been signer ge 2 should be co	Completed			24a. Was an autopsy	prior to co	opsy findings available mpletion of cause of
The	Con			performed′ 1□ Yes 2 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1		23110
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Divisic To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the 1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea				
To the Ho within 24 I To the Fu completel	Medical	one)				o the cause(s)
To To con	2	29b. Signature and title of certifler	29c. License number	29d. ī	Date signed (Month,	Day, Year)
		facel peresty	020806		44104	
10		29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type ATRICK JURUS U.C.) 31. Date filed (Month, Day, Year) 32. Degistrar's Signature ARR 0 6 2009	, Print) (100/180274 Rd)	ELACR	Sike MI	21784
T Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature	lands!		3.7	- 1 / 0 /
Registi	ar	MAR 0 6 2009 Denus B. A				

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	1. Decedent's Name (First, M									2. Date of D)av	Veer	3. Time o	of Death
ian cal	ASHLEY	WAR	field, si	•						Mar	5	²⁰⁰⁹ 2009	061	8:30	Α м
ier	4a. Facility Name (If not instituted 12540 Quiet	Store	n Court			Mt.	Air					Frede		_	
	5. Social Security Number 216–60–8999		M 2□F 49	e (In yrs. last bi	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, I Jan 27	196	50 1	_ Cou	place (State intry) y Land	or Foreig
'n	Usual Residence of Deceder 10a. State 10b. Co MD Fre			10c. City, Tov										10d. Inside (City Limits
Director	10e. Street and Number 12540 Quiet	Strea	3m	PIC.	AIL	10f. Zip	Code 1771	7			10g. (Citizen of Wh	nat Cou		
Funerai	11. Marital Status 1 Never Married		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🐴 N		11	Vas Deced Yes, spec	ent of H	lispanic Ori an, Mexican	gin? (Sp	ecify Yes or N Rican, etc.)	lo-	14. Race Black,	- Amen White,		
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Completed	(Specify only h		College (1-4or 5	5+) P1	life. C	OO NOT us	k done d e retired	auring mos d)	t of won	ang	Van	nSant Plumbing			
To Be C	17. Father's Name (First, Mic Thomas	(die, Last)	Warfiel	d IV				18. Mothe Marg		e (First, Middi L I	_	en Sumame) ndon)		
-	19a. Informant's Name/Rela Marie War	tionship (Ty)	ре, Print) wif	e 1	b. Mailin 254(g Address) Quie	(Street	and Number	or Rui	ral Route Num	ber, City	ry, MD	tate, Zij	0 Code)	
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1	* 4 □ Donation 5 □ Other 21. Signature of Funeral Ser				22	Name and	Addres	ss of Facili	y Bu	rrier-(Road,	uee	n Fune	ral	Home	
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ai Examiner	Due to lor as a consequence of the consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
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Completed	GOUT.		-							per 1 ☐ Yes					
To Be	25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death		ospital:			-		er: 4□Nu	of Dear	th (Check only ome 5 1 e 28d. Describe	sidence	6 Other		fy)	
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edicai			sician: To the best ner: On the basis of and manner sta	f examination a											s)
Σ	29b. Signature and title of ce	tifier	40//			29c.	License D56	e number			29d. [Date signed (

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Main St. M+ Airy

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

Samuel P Eng MD 1502 5.

31. Date filed (Month, Day, Year)

32. Registar's Signature

NAR 0 6 2009 Chium B.

DHMH 17 Rev 1/2001

State Registrar

the

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DAVID DUNN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W.

ORIGINAL

MACPHAIL ROAD, SUITE 106

32. Registrar's Signature

29c. License number

173272

BEL AIR,

MD.

29d. Date signed (Month, Day, Year)

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 3^{Day} MARCH **Physician** 200 gar 10:00pM WINTERLING MARY ANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 9221 NOTTINGWOOD ROAD ROSEDALE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 □ F 65 212-44-5906 Director 3-15-1943 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" ~ " any fijury or other traumatic event." 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Director BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9219 RAVENWOOD ROAD 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) BALTIMORE CITY College (1-4or 5+) Elementary/Secondary (0-12) PRINCIPAL PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEO WINTERLING LORETTA G. (NOVAK) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEAH BARK/SISTER 9221 NOTTINGWOOD ROAD ROSEDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEART JESUS 3-7-09 DUNDALK, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL SACRED HEART JESUS 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Lue to (or as a consequence of): Examiner Sequentially list conditions, Examiner rany, leading to infriedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SISIER'S HOUSE 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Day, Year)

E

MAR 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day **Physician** Year INRIGH 10:29 MARC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Days 912 **Director** Usual Residence of Decedent 10a. State 10b. County City, Town or Location Show 10d. Inside City Limits aţ **Funeral Director** 1 XYes 2 ☐ No must be notified 28a-f Zip-Code 10e. Street and Number 10f 10g. Citizen of What Country? ò or items 23a 16 Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Race - American Indian Black, White, etc. Yes or No Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Yes Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working the Medical 16b. Kind of Business/Industry life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. traumatic event, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ၀ 19a. Informant's Name/Relationship (Type. Print) (brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) If item 27 i Injury or other 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. 22 Name and Address of Facility Joseph L. Kuss Funeral Home 2222 W. North Ave. Batto Md. 2 21. Signature of Funeral Service Licensee once. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart killure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BE SPIRATORY AILURE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tast Mamail Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed2 certificate has 2X No Ýes 1 | Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Hopatient Other: 4 \sum Nursing Home 2000 1 Yes မှ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Watural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or Hospital To the

> State Registrar

Medical

MA 31. Date filed (Month, Day, Year) MAR 0 6 2009

29b. Signature and title of certifier

(check only

32. Registrar's Signature back

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

ES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 9 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:15 AM Her 2 2009 Illiams TICK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number Tear If Under 24 Hrs. Baltimore Medi enter Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 2 M 2 □ F Yrs. 40 Director 02/27/2009 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or iteme 23a or 28e-f ehow other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo **Funeral Directo** Howard MD 10g. Citizen of What Country? 10e. Street and Number #A 10f. Zip Code U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 11990 atuxent death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If Item 27 is marked other than "natural", or ite 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Paula Illian Vaughn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #A turent Pray Department of Health a importent: if Item 27 is any injury or other tre Pau Paula Vaughn 20a. Method of Disposition 11990 Little Columbia mo 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 200 Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HECRA 11 MORE 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ashton, Fu dley Willow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -term **Physician** Pre disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Division of Vital Records, P.O. Box 68760%Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 X No 1 ☐ Yes 2 XN0 1 Yes or Attending Physicien: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 MInpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 SNatural 5 Pending Injury s efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours of To the Funerel I To the Hospitel Medical 🖈 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

ress of person who

Justice

Michela

31. Date filed (Month, Day, Year)
MAR 0 6 2009

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M-D

301

22962

Place,

9-01521 atherine \\/!!!	 .	Please Type or Print in Bl						ble.	10.4
atherine Williar		State of Maryland /	•	nent of He <i>cate of De</i>		lental Hy	/giene	200	07038
Division		Registrar 1. Decedent's Name (First, Middle,Last)	Certini	cate of De	alli		Reg. 2. Date of Death	No.	3. Time of Death
Physicia Medical Exami			m.c				Month E February 20	ay Year	2354 hrs
		Katherine E. William 4a. Facility Name (if not institution, give street and number)		4b. Cit	y, Town, or Loca	ation of Death	1 ebituary 20	4c. County of De	ath
		Maryland General Hospital			timore			N/A	
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last b	irthday) If U	nder 1 Year If	Under 24Hrs.	8. Date of Birth	MM/DD/YYYY) 9.	Birthplace (State or
Director		187-34-8996 1 M 2X F	66		nths Days I	Hours Min.	8/29/3	For	eign Country) Penn
	. 14	Usual Residence of Decedent		·			0/20/	1042	renn
any		10a. State 10b. County	10c. City, Tow	n or Location					10d. Inside City Limits
Aaryland 28a-f show I at once.	ō	Md N/A		Baltin	ore				1 X Yes 2 No
ne Maryland or 28a-f sho Ged at once	Director	10e. Street and Number		10f.	Zip Code		10g	. Citizen of What C	ountry?
the 33 or		301 McMechen Street		2	1217			USA	
h witd rans 2. be n	era	11. Marital Status 12. Was Decedent			edent of Hispani ecify Cuban, Me		ecify Yes or No-	14. Race - Am White, etc	erican Indian, Black,
or ite	Fun	1 Yes 2	XX_{No}		-		rtiouri, ctc.,		
s after	by l	3 Widowed 4 X Divorced If Yes, Give Year or Dates:			2 X No sp			Specify: B	
hour: matu	eted	15. Decedent's Education (Specify only highest grade com		 Decedent's Use during most of 	ual Occupation (working life. DO			6b. Kind of Busines	ss/Industry
36 iin 72 Fran t	ple	Elementary/Secondary (0-12) College (1-4 or 5)+)	0 1				7 1 1	
-00 d with giene flher t	ompl	12 17. Father's Name (First, Middle, Last)		Secret		fother's Name	(First, Middle, Ma		Unniv.
1215-0036 Id be filed within 72 tental Hygiene. rarked other than '	Be C	William Foster				ma Br		den cu mamo,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	- O	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailing Addr				er, City or Town, Sta	ate, Zip Code)
MD d 2 sho lith and n 27 is		Tracey Richardson	Î	540 Mar	shall	Drive	-Apt.1	E.Hoboke	en, New Jer.
e, leah	- ,	20a. Method of Disposition		e of Disposition (latory or other pla	Name of cemeter	ry,	Date :	20c. Location - City	or Town, State
Pages ent of nt: I		Burial 2 X Cremation 3 Removal from Sta Donation 5 Other Specify:	210	co Crem	,	2/2	3/2009	Catoner	ville, Md.
Baltimore, permit. Pages I an Department of Hec Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	MCCI	22. Name a	and Address of F	acility	Funcas	1 Conve	oc.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumartic event, the Medical		Eucum Make Tillal	Y	130	0 Euta	w Pla	ce. Ba	l Servi	Md. 21217
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do	not enter the mo	de of dying, such	n as cardiac o	respiratory arres	, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Atherosclerotic	Cardiovasc	ular Disease					Death
Kaninio		or condition resulting in death) Due to (or as a conse	equence of):						
	ī	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of):		_				_
	ü	Course. Enter Underlying Cause (Disease or injury that initiated	Addition of the						4
₽ PY .≅	Examiner	events resulting in death) Last Due to (or as a conse	equence of):					.,	
executed an and al - transi	ical	d.							
	edic	UNPENDED AMENDED							
Box 68760, death certificate be the attending physicial of for use as the burial	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	ne of pregnanc	y Fetal dea	oth 3 F	ctopic pregna	ncv	23d. Date of delive	ery Day Year
x 6 h cert tendir	cia	past 12 months?	time of death	5 Other (S		otopio progria	iloy	Mona	50,
Bo e deat the at	Phys	1 Yes 2 No 9 V Unknown 9 Unknown							
ires that the signed by 1	by P	Part II. Other significant conditions contributing to death	but not result	ing in the underly	ring cause given	in Part I.			to the cause of death?
S, P.							1 Yes	2 No 3 P	robably 4 🗸 Unknown
ords,	Set						24a. Was an autopsy		autopsy findings available o completion of cause of
Reco The law cate has page 2 s	Completed		-			-	perform 1 Yes 2		? Yes 2 No
Division of Vital Records, P.O. Box 68760, Haspital or Attending Physician: The law requires that the death certificate be 44 hours after death Function: After this certificate has been signed by the attending physiciely filled in by the funeral director, page 2 should be detached for use as the buri	Be C	25. Was case referred to medical			26.Place of D	eath (Check o			
Vita ysici direc	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	ent 2 🗸 ER/	Outpatient 3	DOA Othe	er. 4 Nursin	Home 5 Re	esidence 6 Ot	her:
ing Ph		27. Manner of Death 28a. Date of Inju	ry 28t	. Time of Injury	28c. Injury at	Work?	28d. Describe ho	w injury occurred	
fendi eath or: /	atio	1 Natural 5 Pending 2 Accident Investigation	Sur,		1 Yes	2 No			
Division tal or Attendi rs after death al Director: A	ij		jury - At home,	farm, street, fact	ory, office building	ng, etc.			Rural Route Number, City
Di Huspital 24 hours a Funeral I tely filled	Certification:	4 Homicide determined (Specify)					or Town, Sta	e)	
e Hns 124 h e Fun		29a. Certifier 1 Certifying Physician: To the best of my						,	
Division To the Haspital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/oi						
	Σ	29b. Signature and title of certifier			29c. License nur			9d. Date signed (1	
		Tamety Truthell, My			O.C.M.E			February 21, 2	009
10		30. Name and address of person who completed cause of d		*					
		Pamela E. Southall, MD Assistant Medi		er 111 Pe	nn Street, Ba	altimore, M	ID 21201		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar NAR 0 6 2009	- 6	back	7				
*	_	MAR U O ZUUS I Zhnev					****	-	
DHMH 17 Rev 1/20	01		0	RIGINAL			OCME		

09-01770 David Wiest Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department 1-For State Registrar Certificate		ne Reg. No. 2009 07039
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. De M Ma	ate of Death 3. Time of Death onth Day Year 1312 hrs
	Facility Name (if not institution, give street and number) St. Agnes Hpspital	4b. City, Town, or Location of Death Baltimore	4c. County of Death Baltimore City
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8.1 Months Days Hours Min.	Date of Birth (MW/DD/YYYY) 9. Birthplace (State or Foreign Country) PA
and show any since.	Usual Residence of Decedent 10a. State MD 10b. County Baltimore City 10c. City, Town or Local County 10c. City, Town or Local City	cation	10d. Inside City Limits 1 XYes 2 No
the Maryland as or 28a-f sh utified at once	10e. Street and Number 509 Stamford Rd.	10f. Zip Code 21229	10g. Citizen of What Country? U.S.A.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Peath and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 33a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Ricar Yes 2 X No specify:	white, etc.) White Specify:
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "matural", antic event, the Medical Examiner. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	lent's Usual Dccupation (Give kind of work of most of working life. DO NOT use retired) Contractor	Building
21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Media	Eall Wiest		t, Middle, Maiden Surname) Dorothy "Dottie" (Luchogan)
MD 21 d 2 should th and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Kim Wiest Spouse 19b. Mai 50	ling Address (Street and Number or Rural D9 Stamford Rd. Baltimore, I	Route Number, City or Town, State, Zip Code) MD 21229
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Fredth and Mental Hygiene, Important: If item 27 is marked other ti injury or other transmatic event, the Med	1 Burial 2 Cremation 3 Removal from State crematory or	obsition (Name of cemetery, other place) ic Crematory, LLC Mar (e 20c. Location - City or Town, State O9, 2009 Glen Burnie, MD
Balt permit Depart Impor	3) Signature of Funeral Service Licensee.		Ellicott City, MD 21043
Physician /Medical xaminer	23a. Part Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic car Due to (or as a consequence of):		oiratory arrest, shock, or heart Approximate Interval Between Onset and Death
red Insid	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):		
e execurcian and rial - tra	X UNPENDED d. AMENDED 23a,27,perME,	g889 3/26/09 TT	
6876 certificat anding phi ise as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 9 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
, P.O. Bc res that the dec signed by the a be detached for d by Phys		e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Finneral Director: After this certificate has been signed by the artecompletely filled in by the funeral director, page 2 should be detached for the edical Certification: To Be Completed by Physician and the complete Physician an			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recipion: The scertificate rector, page	25. Was case referred to medical examiner? Hospital: 1 Inneticat 2 P.	26.Place of Death (Check only ent 3 DOA Other Nursing Ho	
Division of Vital Rec Division of Vital Rec within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page edical Certification: To Be Com	27. Manner of Death 28a. Date of Injury 28b. Time	ent o box 4 Mareing Ne	Describe how injury occurred
Division c spital or Attending nours after death. Infled in by the fun Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, s (Specify)	treet, factory, office building, etc. 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the !	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, and due gation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
Me A	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 3, 2009
	30. Name and address of person who completed cause of death (Item 23a) DDnna M. Vincenti, MD Assistant Medical Examiner 1	11 Penn Street, Baltimpre, MD 2	1201
State Registrar			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

		1	1 - State of Maryland		artment of Health			ne No. 2009	07040
F	Physicia		1. Decedent's Name (First, Middle, Last) Mar y	W	illians	2. Date Mor		Day Year 2009	3. Time of Death 04:03 M
	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Location Baltimore City	on of Death		4c. County of Death n/a	
,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat 2 1 2 8 2 6 4 0 0 1 1 1 M 2 x 4 9 Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hour	rs Min. (Mo	e of Birth Inth, Day, Yea	9. Birthp Count 1959 M	
	the Maryland 28a-f show otified at	ctor		Town or Lo	imore 10f. Zip-Code		100.	Citizen of What Coun	1 od. Inside City Limits 1 Yes 2 No try?
36	s after death with , or items 23a or aminer must be n	a a	115 Chesterfield Ave. 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		21213 Was Decedent of Hispanic If Yes, specify Cuban, Mexi	ican, Puerto Rican, e	s or No-	USA 14. Race - Americ Black, White, Specify: Bla	etc.
121215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. ttem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occupation kind of work done during r DO NOT use retired) USEKEEPET 18. Mr	most of working other's Name (First,	W	elcome I den Surname)	
Maryland	ould be f Mental H rarked ot atic ever	To Be	Charles Williams	toh Maili	Do	ris John		ty or Town State 7in	Code
	d 2 th a t7 is tra		19a. Informant's Name/Relationship (Type. Print) Oren Troy Prater (son)	3115	Chesterfi	eld Ave	. Bal	to,Md. 2	1213
Baltimore,	i = i		★ Burial 2 Cremation 3 Removal from State C6	emetery, cre Lnity	osition (Name of matory or other place) Cemetery	1	2009		
Balti	permit. Pa Departmen Important: any injury once.		21. Stofature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		2. Name and Address of Fa Alvin B. S 412 E. Pre	cruggs ston St	Funer Bal	al Home to,Md. 2	1213 Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	901 5	eps is	mas cardiae or respi	Tatory arrost,		Interval Between Onset and Death 7 days
760,	ate be executed hysician and the burial-transit	dical Examiner		MINUNO eriče dij.	deficiency S	yndrome			10 years
Box 68	death certific e attending pl ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Yea r
ds, P.O.	w requires that the been signed by should be detail	ğ	Part II. Other significant conditions contributing to death but not resu	ulting in the	underlying cause given in I	Part I. 23	Be. Did tobac	co use contribute to	
I Recor	ician: The law requires that the certificate has been signed by the rector, page 2 should be detach	Completed				— I.	a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vita		To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No Hospital: 1 \sum Inpatient 2 \sum 1	ER/Outpatie	Othor	lace of Death Chec Nursing Home 5		e 6 🗆 Other (Specif	
Division of Vital Records,	or Attending after death. Sirector: After in by the fune	Certification: 1	27. Manner of Death 1★Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 ☐ Could not be determined 28e. Place of injury - At hor building, etc. (Specify)		M 1 ☐ Yes 2	2 No 28f. Lo		injury occurred et and Number or Rui tate)	ral Route Number,
	To the Hospital or Att within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	vledge, deat ion and/or i	th occurred at the time, dat nvestigation, in my opinion,	te and place, and du , death occurred at t	le to the caus the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
7	To the vithin To the comp	Me	29b. Signature and title of certifier Destruction Des	or	29c. License numb		100	Date signed (Month, arch 04	Day, Year) 2009
	Sta	ite	30. Name and address of person who completed cause of death (Item Justin Bachmann, Johns Hoyki 31. Date filed (Month, Day, Year) 32. Registrar's Signate MAR 0 6 2009	n 23a) (Type	spital	600 Nort	h Wolfe	St, Baltimo	re, MD, 21287
	Regist		MAR 0 6 2009 Source A	a. 14					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28b,d,f per me,g889.03/05/09dhb, Reg. No. 2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Anthony Bernard Andrews, Jr. Year Februs 2009

4b. City, Town, or Location of Death

1106 M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

3 ☐ Probably 4 ☐ Unknown

30 No

1 ☐ Yes 2 No

Maryland

White

4c. County of Death

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Funeral** Director 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Me II al Examiner must be notified at Directo Funeral Maryland 21215-0036 \$ Completed 2 should be f and Mental F Health Hem 27 I Baltimore, If Item Pages 1 permit. Pages Department of Important: If it any Injury or o Physician /Medical

3

Venal

Examiner

ed by the attending physician and detached for use as the burial-tran for use as been signed by t should be detach cate has by page 2 s certificate funeral To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu

1986, 44 to be countersing

Hospital Sinai Bultimore of Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 X M 2 ☐ F Jan. 6, 219-32-9627 Usual Residence of Decedent 10c. City, Town or Location 10b. County Maryland | Baltimore Woodlawn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21244 USA 2108 Kalb Manor Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Instructor Culinary Art School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Bernard Andrews, Sr. Mary Angelia Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Wife 2108 Kalb Manor Road; Woodlawn, Maryland 21244 Anne Marie Andrews 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Rosary Cemetery 3/4/2009 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 100 190/490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardyo Due to or as a consequence of): indival Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CERTIFICATION APPROVE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dependent 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3☐ No 24a. Was an autopsy performed iger tersor 1□ Yes 25. Was ca eferred to medical examiner? Be 26. Place of Death (Check only one) 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2□ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 10:30 PM 5 ☐ Pending Subject fell. Februar 22,200 2 Accident 3 Suicide 1 ☐ Yes 2 No investigation 6 ☐ Could not be 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Bural Boute Number, City or Town, State) 2108 Kalb Rd. 4 ☐ Homicide determined A none Woodlawn,MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of persor e of death (Item 23a) (Type, Print) Since Hispital of Bultimore arter 82. Registrar s Signature 31. Date filed (Month, Day, Year)

State Registrar

MAR 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 655 **Physician** BOLGER MARCH HOMAS 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTI MORE COOOD SAMARIMAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 12/29/1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min M 2 F MARYLAND 79 Director 219-28-2128 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Nedical Examinations to a collision 1 ☐ Yes 21 No Director PARKVILLE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA Funeral 8546 OAKLEIGH ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. M∏Yes 2 ☐ No If Yes, Give Year or DatesKOREA 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify Specify: <u>م</u> WHITE 3 Divorced 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHILLIP ENGINEERING MASTER WELDER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN COLLINS DANIEL J. BOLGER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a BALTIMORE, MD 21234 8546 OAKLEIGH ROAD DOROTHY BOLGER/WIFE Item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. = 5 3/9/2009 HILLENDALE, MD MORELAND MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Censee MO1139 107 21286 8521 LOCH RAVEN BLVD. TOWOSN, Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPHY'KI ATON **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): 24 HOURS Examiner THROAT SURGER Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Excas a consequence of Examine NECK MASS law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ HYPERTENSION 1 Yes 2 → No 3 Probably 4 Unknown cate has been signated by page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician: The 2 🗆 No 1 ☐ Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 1 24 hours after death.

In Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only

BOLGER PT# 1021060767 MR#901013960

03/05/09

State Registrar

GOOD SANARTAN HOJATAL, 5601 LOOH RAVON BOULEVARD KOSTRUBAL) 9 **200**9 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

M

within 2

29c. License number

30950

MD

29d. Date signed (Month, Day, Year)

MARCH 5, 2009

BALTIHOLE, MULLIZE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Barry March 5, Mark Bloom 2009 10:44 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/19/1962 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Hours Min. 1√2 M 2 □ F Months Days 214 90 7751 47 **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the five first increased to mylified at 1∏Yes 2∏No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Oliver Street 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛛 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Automobile ath and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bloom Frances Wilhite ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Denise Bloom (wife) 5009 Oliver Street Baltimore Md 21205 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Bayview Crematory Inc: 3/6/2009 Baltimore Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or amplications that, aused the death. shock, in heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death monot enter the mode of dying, such as cardiac or respiratory arrest, **Physician** LIVER CANC disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter I have not cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been sig 7, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 □No 1 ☐ Yes 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Softher (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 24 hours after death. 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division of Vital Records,

MARO 92009 DHMH 17 Rev 1/2001

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of p

6565 N

rson who completed cause of death (Item 23a) (Type, Print)

mo 82. Registrar's Signature

DOBERMAN.

29c. License number 74395

29d. Date signed (Month, Day, Year)

MARCH 5, 2009

CHARLES ST, SUITE 209 BALTIMOTE, MD 21204

		Please 7	Type or Prin						_	jible.	3
		For State Registrar	State of Ma	arylan	•	artment of F rtificate of	lealth and N Death		iene eg. No. 🤈	200	ווחדח
_		Registrar Decedent's Name (First, Middle, Last	")			· imouto or		2. Date of Deat	h	כטע	3. Time of Death
Physicia /Medic		Jeannette M. Bur	ks					March 5,	2009	Year	12:46 PM
Examin	er	4a. Facility Name (If not institution, give 816 North Woodlynn				4b. City, Town, o	r Location of Death			ty of Death Limore	
Funeral Director		Social Security Number 6. S		e (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/02/19	Year) 922	Cou	place (State or Foreign ntry) ginia
pug »		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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or 28a	Direc	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	f What Cou	ntry?
s 23a	eral	816 North Woodlynn		1	0 10	21221	E		U.S.A		to die
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinat must be notified at once.	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give			was Decedent of F If Yes, specify Cub 1 □ Yes ※XXNo	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		ace - Ameri ack, White,	etc.
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d be fill ental H ced otl	Be C	17. Father's Name (First, Middle, Last) John Wesley Martin					18. Mother's Nam Dessie Sy		viaiden Surna	ame)	
should and Me s mark umatic	은	19a. Informant's Name/Relationship (7)			19b. Maili		and Number or Rui		; City or Tow	n, State, Zi	p Code)
and 2 lealth a m 27 ls		Lowell Martin (Nep	hew)				Avenue,				
ages 1 nt of H t: If Ite		20a. Method of Disposition ★★Burial 2 ☐ Cremation 3 ☐				osition (Name of matory or other pla-	urch03/14		^{20c.} Location Gladys	,	
mit. Pa partme sortant Injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fundal Service accept	569	rec		-	ess of Eacility uzdzinski	1	_	•	
Der Der any		Muchand /	my	1		1407 Ola	<u>Eastern</u>	venue, i	essex,	Mary	land 21221
Physician /Medical		23a Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hype	the death	110	AHNEOSC	ng, such as cardiac Lerodic Co	or respiratory arm	est, culcro	user	Approximate Interval Between Onset and Death
Examiner	J.	Sequentially list conditions,	b								
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	a consequ	dence oi;						
cia cia	al Ex	resulting in death) Last	Due to (or as	a consequ	uence of):						
fficate physics the b	edica		d								
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	☐ Ectopic pregnand ☐ Other (specify) _	Cy .			ate of deliv	very Day Year
w requires that the described speed signed by the should be detached	by Ph	Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol			the cause of death?
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The law cate has by	Completed							24a. Was a autops perforr	sy	prior to co death?	opsy findings available ompletion of cause of 2 ☐ No
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ng Phys (fter this ineral di	Certification: To	1 Yes 27 No 27. Manner of Death 12 Natural 5 ☐ Pending	1 ∐ Inpati 28a. Date of Inju (Month, Da	iry	28b. Time o Injury	f 28c. Inju	ry at k?	28d. Describe ho	ence 6 Co ow injury occ	. ,	(fy)
Attendi	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	ury - At ho	ome, farm, sti	M 1 Creet, factory, office	Yes 2□No	28f. Location (St	treet and Nur	nber or Rui	ral Route Number,
tal or restrer safter al Dire	Certi	4 ☐ Homicide determined	building, et	c. (Specif	(y)			City or Town	n, State)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one) 1 CertifyIng Physical Example (Check only one)	/sician: To the best iner: On the basis of and manner st	of examina	owledge, deat ation and/or in	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the d rred at the time, d	ause(s) and late and place	manner as e, and due	stated. to the cause(s)
Vithi Vott	ž	29b. Signature and title of certifier	140. 1410			29c. Licens	se number		9d. Date sign		Day, Year)
		Mulden Mu 30. Name and address of person who of		leath (Iton	n 23a) (Tune	Print)	8760		03/0		XUU-
10 1		Sheldon Milr					n'a Road	Balt	U.m	Dé	11237
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2009	Serent 32. Hegisti	Ars Signa	Allo Pr	V					

09-01741 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rudolph Bynum State of Maryland / Department of Health and Mental Hygiene 2009 07045 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 1, 2009 **Medical Examiner** 1220 hrs dol nun 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 3700 Greenspring Avenue Apt. 816 Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** 8. Date of Birth (MM/DD/YYYY) Director - 28-1957 ma. 1 V M 2 214-56-5070 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 28a-f show VYes 2 the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 233 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married Married Yes 9 more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Widowed Divorced Give Yea Yes 2 No specify: "natural" event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ other than Disable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be (1a 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) item 27 is m tranmatic e ndia daughter OWINGS MILLS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 2 VCremation 3 crematory or other place) Burial Removal from State -09 Donation 5 Other Specify 21. Signature of Fune of Service Licensee 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva failure. List only one cause on each line. /Medical Between Onset and Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last requires that the death certificate be executed Physician/Medical 23a,PII,27,perME, g890 4/16/09 per FH, X UNPENDED ending physician use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cocaine use; chronic obstructive pulmonary disease Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? VYes 2 2 Nο 1 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) **Division of Vital** Be Other: Hospital: DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene မှ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural death. Pending Yes 2 the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

To the Hospital or Attending Physician: The law Funeral Director: within 2. To the F

> 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 2, 2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day William R. Bull, Sr. March 4, 2009 /Medical 6:00 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 3050 Chestnut Hill Drive Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Months 217-40-6421 **Director** 66 Jan. 18,1943 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "nature." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3050 Chestnut Hill Funeral Drive 21043 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles Stanley Bull, Sr. Ruby Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bull Wife 3050 Chestnut Hill Drive; Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3-7-2009 Glen Burnie, Maryland Sterling Ashton Schwab Witzke Catonsville, Inc. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Funeral Home of 1630 Edmondson Avenue; Catonsville. MD 21228 23a. l art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Isdaemic 2+440 /Medical Due to (or as a consequence of): **Examiner** 2000 Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Course and Due to (or as a consequ Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 ☐ Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Tyes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only Medical Examiner: On the mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certification

30. Name and address of person

no completed cause of death (Item 23a) (Type, Print)

29c. License number

028246

10298 B Baltimore National Pike

Ellicott City, MD 21042

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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or 28a-f sl		MD			BALT	CIMORE						1 XYes 2 □ No
with the		e. Street and Nur					10f. Zip Code			10g. Citizen of	What Coun	try?
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Division of Vital Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, polical Certification: To Be Co		3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place of building	f Injury - At hor g, etc. <i>(Specify</i>	me, farm, stre	eet, factory, office			(Street and Num wn, State)	ber or Rura	l Route Number,
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fun Medical Certification		Pa. Certifier (Check only one)		Physician: To the baminer: On the baminer	sis of examinat							
To the within To the comp	29	9b. Signature and	title of certifier				29c. Licens	e number		29d. Date sign		
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State Registrar		. Date filed (Mon	nth, Day, Year) AR 0 9 20	ng Perte	gistrar's Signat	par par	R					

09-01719 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lester Burchett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ I. Decedent's Name (First, Middle,Last) Month Day February 28, 2009 **Medical Examiner** LESTER EDDIUS BURCHETT, III 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. Director 1 X M 1 1971 215–04–5026 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show ust be notified at once. BALTIMORE DUNDALK MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7150 EASTBROOK AVE 21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc Armed Forces? 2 X Married Never Married Yes 2 X No Specify: WHITE If Yes, Give Year Yes 2 X No specify: Divorced "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) ID 21215-0036 2 should be filed within 72 ho and Mental Hygene Elementary/Secondary (0-12) College (1-4 or 5+) the Medical is marked other than DRYWALL HANGER PRIVATE 12TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nt: If ite, t 27 is marked other traumatic event, Be JUDITH SCHULDT LESTER E, BURCHETT, JR è 19a. Informant's Name/Relationship (Type, Print) DUNDALK MD Pages 1 and 2 s ment of Health a CYNTHIA BURCHETT/WIFE EASTBROOK AVE., 7150 0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State rtant: Donation 5 Other Specify ARDENT 'n 21. Signature of Funeral Service Licenses **Physician** failure. List only or e cause on each line, /Medical Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit ca 23a,27,perM,E g889 3/31/09 #1 as noted, XUNPENDED AMENDED signed by the attending physician be detached for use as the burial Physician/Med IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) No 9 Unknown Yes 2 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 24a. Was an autopsy performed? certificate Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical director, Be Other₄ examiner? Hospital: DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 this 2 1 V Yes No 28a. Date of Injury (Month, Day,Year) After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death tΧ Natural Yes 2 No Pending 2 Accident Investigation

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c, Location - City or Town, State 03/04/2009 | HANOVER, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, 21231 23a, Part I, Enter the due se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Hypertensive atherosclerotic cardiovascular disease Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Nο Fo the Hospital or Attending Physician: Residence 6 Other 28d. Describe how injury occurred Certification: Division death Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 1, 2009 O.C.M.E. Mante 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra

DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year)

ORIGINAL

32

OCME

1352 hrs

10d. Inside City Limits

1 X Yes 2 No

Foreign

Country) MD

Physicia /Medic

Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Experiment must be retified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit State

n al er	Decedent's Name (First, Middle, Last) Emma K. 4a. Facility Name (If not institution, give st. Gilchrist Hospice C		Cyzy	k		2. Date of De Month March	Day	009 Y	'ear	3. Time o 9:50	
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lrec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of Wh	at Cou	ntry?	
Funeral Directo	1923 Robinwood Road	1		2122	2			US	A		
ıner	11. Marital Status	2. Was Decedent Ever	în U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No)-	14. Race - Black,	Ameri	ican Indian,	
ò	1 ☐ Never Married 2 ☐ Married 3 🖔 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ XNo	Specify:	1110011, 010.7		Specify V			
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Be C	17. Father's Name (First, Middle, Last)		110	asewire	18. Mother's Name	e (First, Middle,					
OB	Jacob Kucenski				Mary Per	ncek					
	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mai	ling Address (Street a	and Number or Rur	al Route Numb	er, City o	r Town, Si	tate, Zi	p Code)	
	Leonard A. Cyzyk	son		ppletree L		araiso,	IN	4638	3		
	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			position (<i>Nam</i> e of ematory or other place utheran Ce		,			•	own, State	1
	21. Signature of Funeral Service Licensee		0	22. Name and Addres	s of Facility uneral Ho	ome Of I	Dunda	alk.P	.A.	-	•
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	23a. Part 1. Enter the disease, o complici shock, or heart failure. Use only one Immediate Cause (Final	cause on each line.	Jogn Boller	mor the mode of dynn	g, odori do odraido	or respiratory a	111031,			Interval Be Onset and	tween Death
	disease or condition resulting in death)	Due to (or as a cor	rsequence of):						-	WEEK	<u>-S</u>
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edical Examiner		Due to (or as a cor	nsequence or):								
gic	d.										
Ž	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pr						23d. Date	of deliv	verv	
Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)	′			Mont		•	Year
	Part II. Other significant conditions conti	ributing to death but no	t resulting in the	underlying cause give	en in Part I.	23e. Did 1	tobacco u	se contrib	ute to	the cause of	death?
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Completed	<u> </u>					24a. Was		24b. We	ere aut	opsy findings	available
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0	1 Yes 2 No Ho		2 ER/Outpati		4 LI Nursing Ho					ity) Hosi	PICE
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fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, s		ies Z 🗆 ito	28f. Location (Street an	d Number	or Rui	ral Route Nur	mber.
erti	4 ☐ Homicide determined	building, etc. (S	pecify)	•		City or To	wn, State)			
Medical Certification: To	29a. Certifier 1 Certifying Physi (Check only one) Medical Examin	clan: To the best of meer: On the basis of exa	y knowledge, de mination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s)	and man place, an	ner as	stated. to the cause(s)
Me	29b. Signature and title of certifier	and mainter stated.		29c. License	number		29d. Dat	te signed (Month	, Day, Year)	
	100	26)1	~	Die	4395	1.	MARI	146	, 21	009	
		1/		20			1111-6	" 4	, ,	- 1	
	30. Name and address of person who con	npleted cause of death	(Item 23a) (Type	e, Print)							
	DANIEUT DOBERM	mpleted cause of death MV, MO 6	(Item 23a) (Type 565 A	1 MARIJE	ST. 841	TE 209	BAL	MAR	E, K	10 212	04

Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 5:45 A M March 8, Coveleskie Helen Barbara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Woods Nursing Center Rossville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 01/06/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2X F 189-09-3815 91 Massachusetts Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural, or items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examination to collided at 1 ☐ Yes 2XXVo Middle River Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21220 U.S.A. 28 Chandelle Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2CXNo Specify: If Yes, Give Year or Dates: Specify: White 3₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susan Motel Alexander Zaleski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 28 Chandelle Road, Baltimore, Maryland 21220 Walter Coveleskie, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 03/12/2009 Faltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signal of yer runeral States Licensee <u> 1407 Old Eastern Avenue, Essex, Maryland 21221</u> Approximate Interval Between Onset and Death 23a. Part: Option the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final dise — e or condition rewiting in death) METASTATIC Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐NO Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown ナナン Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2[2No 1 ☐ Yes 2 🗆 Ne Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral C to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D40008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUARE PARSHALL BALTIMORE 9105 FRANKLIN

State Registrar

31. Date filed (Month, Day, Year) MARO 92009 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009 for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 March 6, **Physician** 4:56 P M Collins Shirley Goldie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 409 Mace Avenue If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F 02/19/1931 Maryland 78Yrs 218-28-8265 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience is use to an effect of 1 ☐ Yes 27 No Director Essex Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 U.S.A. 409 Mace Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. ₩XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXIIo Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Collins Margaret Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 365 Upperlanding Road, Essex, Maryland 21221 Norma E. Spence (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 03/10/2009 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ski Funeral Home, P.A. 21. Signature of Full al Savice Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Part 1. Enty, the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Onset and Death Immediate ause (Final disease condition resulting death) Physician /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 X No the 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No dea h. the To the Hospital or Atterwithin 24 hours a er dead To the Funeral Director 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Mysical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) License number 29b. Signature and title 30 ne and add ss of person ted cause of death (Item 23a) (Type, Print

Registrar DHMH 17 Rev 1/2001

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Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 100 2009 Vincent Joseph Cascio, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Franklin Square 5. Social Security Number 1 6. Sex ente sedal more Tal If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 07/29/1925 Months Days Hours Maryland 1⊠M 2□ F 220-14-0263 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🛛 No Rosedale Baltimore Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21237 U.S.A. 4 Higan Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1043 11. Marital Status 1 XYes 2 No 1943-1 ☐ Never Married 2 M Married If Yes, Give Year or Dates: 1∐Yes 2⊠No Specify Specify: White 1946 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Insurance 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Ventrulla Joseph Cascio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Higan Court, Baltimore, Maryland 21237 Ruth Cascio (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 03/10/2009 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith |Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease r condition resulting in death) Hemorthagic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown fa 24b. Were autopsy findings available prior to completion of cause of death? reno autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes / 2 🐼 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Madical Examinar must be notified at once.

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Pages 1 and 2 should be 1 ment of Health and Mental

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and burial-trai attending physician for use as the buria signed by the a cate has t

Box 68760,

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Records,

Division of Vital

certificate

Physician/Medical Exami Be Completed by Certification: To

ner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State Registrar

Medical

2 Accident 6 □ Could not be 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

r Mohamad Alabra

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

(Check only one)

29a, Certifier

9 2009

State of Maryland / Department of Health and Mental Hygien U U 9

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MARCH 3, **Physician** 2009 CROUT MARY L. 7:46 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛱 F 74 219-40-7381 1935 NORTH CAROLINA Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "naturel", or iteme 23a or 28a-f shov ofical Examinar must be notified at Yes 2□No Director BALTIMORE MD. N/A10g. Citizen of What Country?
UNITED STATES 10e. Street and Number 10f. Zip Code 21224 524 S. LEHIGH ST. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than 900.00. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 6TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GIBBS LEAR AN PRESTON CHAVIS 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*524 S. LEHIGH ST., BALTIMORE, MARYLAND 2122 19a. Informant's Name/Relationship (Type, Print) ROGER SMITH/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 3/7/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** auc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) cete has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 20 No certificete 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manger of Death 28c. 28d. Describe how injury occurred Certification: Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai (Check only one) and manner stated. the within To the 29c. License number 29b. Signature and title of certifier 135170 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808-810 CONKLING ST BALTO MI) 31. Date filed (Month, Day, Year) State MAR 0 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07054 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ANDREW CHORNEY 430 AM MARCIN 2009 Eacility Name (If not institution, give street and number; 4b. City, Towd, or Location of Death 4c. County of Death WERS 8. Date of Birth (Month, Day, Year) 28, 1922 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1**∑**M 2□ F Months Days Hours 215-30-5350 86 UKRAINE Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XXNo MD HARFORD KINGSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 WHITT ROAD 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEERING SUPERVISOR DOMINO SUGAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MYCHAJLO CHORNEY ANNA DOLNYSKA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIA CHORNEY/ WIFE 2415 WHITT ROAD, KINGSVILLE, MARYLAND 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MICHAEL'S UKRAINIAN 3/7/09 BALTIMORE, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy aZ No 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of ath Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician:

and burial-tra attending physician use as the signed by pe page 2 certificate filled in by the funeral director, After this Director; To the Hospital within 24 hours To the Funeral

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner my

Director

Funeral

Completed by

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Certification: To

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4 ☐ Homicide

(Check only one)

29a, Certifier

filed within 72 hours after death with the Maryland

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Injury or Department of Important: If any Injury or once.

Physician

/Medical Examiner

Maryland 21215-0036

Baltimore,

Registrar

State

Year)

determined

29b. Signature and title of certifier

and manner stated

29c. License number

1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State	of Mary	land / Dep					/	nng	07055
		_	Registrar 1. Decedent's Name (First, Middle	(not)			ertificate	or Dear	.77	2. Date of Dea	Reg. No.		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution		·	INE		wn, or Location	on of Death	tebru		ounty of Death	17 7
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	Funeral			6. Sex	7. Age (In	yrs. last birthda) If Under 1		der 24 Hrs.	8. Date of Birt (Month, Da	h V Year)	9. Birthp	place (State or Foreign
	Director		220-24-4783	1 □ M 2 🙀 F		95 Yrs.	IVIOITIIS	Days	S IVIIII.	JAN. 19			MD
	and w		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town or I	ocation			_			0d. Inside City Limits
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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Modical Eva , the court be mailfied at	Director	MD 10e. Street and Number			BALTIMO	10f. Zip C	ode			10g. Citize	n of What Cour	ntry?
	3a or		401 N. ELLWOOD	CTP			2122	2/			USA		
	death	Funeral	11. Marital Status	12. Was Dec	cedent Ever	in U.S. 13	Was Deceder	nt of Hispanic	Origin? (Sp	ecify Yes or No-		. Race - Americ	
9	after or Ite		1 ☐ Never Married 2 ☐ Marrie	Armed F 1 □ Yes If Yes, G	2 X No		1 ☐ Yes 22	/ Cuban, Mexi ∑ No <i>Sp</i> ec		nican, etc.)		Black, White, pec <i>ify:</i> BLA	
5-0036	ural",	d by	3 XWidowed 4 ☐ Divorced	Year or I	Dates:				nry.				
<u>2</u>	I within 72 ho giene. r than "natu the wedies!	Completed	15. Decedent' (Specify only highes	s Education t grade completed	1)	(Giv	edent's Usual (e <i>kind of work :</i> D <i>O NOT us</i> e	done during m	nost of worki	ing	16b. Kind	of Business/In	dustry
7	withir ene. than	d mc	Elementary/Secondary (0-12) 12TH	College	(1-4or 5+)		ESSER	reureaj			Τλ	UNDRY	
ק ס	be filed trail Hygi d other event, tr		17. Father's Name (First, Middle, L	_ast)		PK	ESSER	18. Mc	other's Name	e (First, Middle,			
<u>a</u>	e d t p	To Be	JOSEPH DIGGS					Ε'Ā	NNTE: I	M. DTGG	3		
Maryland	rs or F		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mai	ing Address (S			al Route Numbe		own, State, Zip	Code)
_	and 2 ealth a n 27 is ner tra		DIANE RUSSELL/	GRANDDAU	GHTER	40	1 N. EI	LLWOOD	AVE.,	BALTIM	ORE, I	MD 212	224
e C	of He of Her roth		20a. Method of Disposition	2 III D f	20	0b. Place of Disp cemetery, cr				Date		tion - City or To	
Ĕ	Pages ment of ant: If its ury or o		1 ½ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other <i>(Sp</i>		n State	BALTI	MORE NA	TIONAL	03/06	/2009	BALT	IMORE.	MD
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service L	icensee /	1		22. Name and	Address of Fa	cility WES	LEY CHA	VIS,	JR. FNR	L. HM.
п	70 E # 9		Wesley	Chan	<i>-()-</i>		2007-0	9 EAST	ERN A	VE., BA	LTIMO	RE, MD	21231
			23a. Part 1. Enter the disease, or a shock, or heart failure. List of	complications that only one cause on	caused the each line.	death. Do not e	nter the mode	of dying, such	as cardiac	or espiratory ar	rest,	1 1	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_a/]	The	rosc	lero	1c1	is-a	IOVA	au	a M	sea p
	/Medical Examiner		resulting in death)	Due to	o (or as a cor	nsequence of):			,				
		-	Sequentially list conditions,	b	ilin as a un	isequence of.						7.2	
	uted f insit	m in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	54010	(0, 40 4 00)	tooquonoo oty.							
	be executed ician and ourial-transit	Examine	that initiated events resulting in death) Last	c Due to	o (or as a cor	nsequence of):							
3	cate be executed physician and the burial-transit	dical		d									
8	tifica ng ph as th	edi	12.22.12										
X R R	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pr		☐ Ectopic pre	anancy			230	d. Date of deliv	
_	0 0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time		Other (spec					Month	Day Year
ī.	requires that the de een signed by the a nould be detached f	Phy	9 Unknown	1			and a de da an ana			20a Did to		. contribute to t	he source of death?
Š,	res the signer be d	ρ	Part II. Other significant condition	ns contributing to t	death but no	t resulting in the	underlying cau	se given in Pa	art I.		es 2□		he cause of death? bably 4 Unknown
ecords	requi	Completed					_			Transfer .			
ě	e 2 sh	ם								24a. Was autop	an sy	24b. Were auto prior to co death?	opsy findings available impletion of cause of
	ician: The law requir certificate has been s rector, page 2 should									1 □ Yes	med? 2 kgNo	1 ☐ Yes	2 □ No
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ō	ding Physician: The I.h. h. After this certificate ha funeral director, page	5	1 Yes 2 No 27. Manner of eath	1 1 1		2 ☐ ER/Outpati 28b. Time		4 🗆		me 5 Residence 128d. Describe h			fy)
0	dlng th. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investig		e of Injury onth Day Yea	ar) Injury	м	i. Injury at Work? 1 □ Yes 2		2001 20001120 1	ov mjery e		
VISION	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury -	At home, farm, s pecify)	treet, factory, o	office		28f. Location (S	Street and I	Number or Rura	al Route Number,
5	al or	Certification:	4 ☐ Homicide determin	build	aing, etc. (S)	респу)			4	City or Tow	n, State)		
	ospit hours unera ly fille	ial C	29a. Certifier 1 ertifying (Check only Medical E	g Physician: To th Examiner: On the	ne best of my	y knowledge, de	ath occurred at	the time, date	e and place,	and due to the	cause(s) a	nd manner as	stated.
	the H iin 24 the Fi	edical	one)	and ma	inner stated.								
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Σ	29b. Signature and title of certifier	XX	1		29c. L	License numb	er	7 .	29d. Date s	signed (Month,	Day, Year)
			· way	0/0			$ \ell$	1158	10	X H	chr	un ?	28, 2009
			30. Name and address of person v	who completed cau	use of death	(Item 23a) (Type	Print)	11	-6	7/	12	/ /	
		to.	31. Date filed (Month, Day, Year)	30 K	Registrar's S	Signature	4/1/	1 me	00		124	2	
	Sta Registr		MAR 0 9 2	009 12	dua	Signature	while				,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** Year 10:30 Å RUBY IRENE COOPER FEB. 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) BRINTON WOODS of FRANKFORD, LLC (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Funeral 1 M 2 XF Director 228-72-7951 56 JUL. 17, 1952 VA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 X Yes 2 □ No by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 23a APT. #1A 920 BELGINA AVE. 21218 USA Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 21 No 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 11TH **GOVERNMENT** CUSTODIAN Department of Health and Mental Hygis Important: If them 27 Is marked other any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ GEORGE EUBANKS MARGARET DELOATCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERESA YOUNGER/DAUGHTER 21218 920 BELGINA AVE. - APT. #1A, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8710 DOGWOOD RD. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 03/05/2009 | WINDSOR MILL, MD KING MEMORIAL 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service License 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Enter the dises caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as IF FFMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) I Ves 2 □ No Jivision or Vital Records, P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Onknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an er this certificate has eral director, page 2 autopsy performe 2 No Hospitation Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director a completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) $\sim MD$ althorn Woods Road. MD 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAR 0 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:00 A^M 2009 FFB WILLIAM KIRKWOOD DICK, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SEASONS HOSPICE RANDALLSTOWN BALTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 M 2 □ F Director AUG. 2, 1944 212-40-1969 64 MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, it will mark it is not the natural once. 1 X Yes 2 □ No Director MD BALTIMORE DUNDALK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2060 LARKALL RD. 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 XNever Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOME REPAIR SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ WILLIAM K. DICK, JR. LOLA M. CORSEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2060 LARKALL RD., DUNDALK, MD 21222 TAMMY DICK/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/27/2009 HANOVER, MD ARDENT 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Mesley 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart takere. List only one cause on each line. Immediate Cause (Final Sta Physician End disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Proneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌴 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes You 24a. Was an autopsy 1 □Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specify) rto SPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) Medical (Check only one) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or Debug Bwtm 2835 Sm Lth hierule Biltimaro MD 166616 31. Date filed (Month, Day, Year) State MAR 0 9 2009 Registrar

Month Esteon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 60 Lauretta Baltmore Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. **Funeral** Days Months Hours 243-24-681 29 1424 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, I'm Medical Exantinal coust by retitled at **Funeral Director** wo Babtimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2/223 260 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) struction Worker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) doing hter Bathanora 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills mo toras 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service/License 22. Name and Address of Facility 270 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook/or reart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) non-small cell **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death. • Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 🔲 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) North Com 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

giene Reg. No. 2009

Year

2009

7:00 AM

9. Birthplace (State or Foreign Country) North Cerrolina

mo 2/229

Month

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Bartimure Mb 21201.

Day

3 Probably 4 Unknown

Approximate Interval Between Onset and Death

one year

Year

10d. Inside City Limits

1 Yes 2 □ No

2. Date of Death

Division of Vital Records,

641

within 2.

State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6 ☐ Could not be

1, Decedent's Name (First, Middle, Last)

Physician

Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

s. (reenest

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Plea						. Ensure All Health and M	_		.egible	
	-	For State Registrar		Sta	ate or ivi	aryları		rtificate of i			grene Reg. No.	200	9 07059
		Decedent's Name	e (First, Middle	e, Last)		-				2. Date of Dea		Yea	3. Time of Death
Physicia /Medic		John Patr	cick De	Angelo)					March 8			7:00 A ^M
Examin	er	4a. Facility Name (/			and number)			4b. City, Town, or	r Location of Death			County of De	
		1611 Will 5. Social Security N		venue	7 Ac	e (In vrs	last birthday)	Essex If Under 1 Year	ltimo	CE Birthplace (State or Foreign			
Funeral Director		304-48-22		1 √∑ tM 2		63	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 07/03/1	y, Year) 945		Country) nnsylvania
		Usual Residence of	f Decedent			T							
arylar show	۲	10a. State Maryland	10b. County Balti	more		Esse	y, Town or Lo	ocation					10d. Inside City Limits 1 □Yes 2\(\frac{1}{2}\)\(\text{No} \)
the M 28a-f	Director	10e. Street and Nur		more		Lass		10f. Zip Code			10a, Citiz	en of What	Country?
		1611 Will		venue				2122	21		-	.S.A.	ŕ
death	Funeral	11. Marital Status		12. W	as Decedent	Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	1	4. Race - Ai Black, Wh	merican Indian,
or ite	by Fu	1 Never Marr		ried 12	©∆Yes 2 □ Yes, Give	No 19	66-	1 ∐Yes 2/⊡X No		,		Specific:	
hours tural"	ed b	3 Widowed	4 ☐ Divorced		ear or Dates:	19		dent's Usual Occup	pation		16b. Kin	d of Busines	White ss/Industry
in 72 in "na //edic	plet	(Spec	cify only highe	st grade com		5.1	(Give	kind of work done DO NOT use retired	during most of work	ing			,
d with	Be Completed	Liemental y/3eco			1		Accou	ntant				untin	3
be file		17. Father's Name	,	,					18. Mother's Nam			Surname)	
ould Mer narke natic	٩	Francis J					405 14-115	- Address (Carosa	Laura Ali	-		Town State	Zin Codo)
d 2 st Ith an 17 is r traur		Shirley A			,		1		Avenue, I				
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, I'm Medical Evantions.		20a, Method of Dis	position					osition (Name of matory or other place		Date			or Town, State
Pages nent o int: If		1 Burial 2 Donation			al from State					10/2009	Cro	wnsvi	lle,Maryland
rmit. spartn porta y inju		21. Signature of Ft	uneral Service	Licensee			2	2 Name and Addre	see of Escility				
89 E 8 8	. ,	1/2	25	6								Mar	.A. yland 21221
	,	shock, or hea	art failure. List	complication only one gai	use on each li	ne.		a	ng, such as cardiac			`	Approximate Interval Between Onset and Death
Physician /Medical		Immediate cause disease or condition resulting in death)	(Final on	-1			EROTI	C CAI	RDIOVA	SCULA	<u> </u>	DISG	MSE
Examiner					Due to (or as	a conseq	uence of):						
7	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, nmediate	b. —	Due to (or as	a conseq	uence of):						
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ficate be exe physician as the burial-		resulting in death)	Lasi	l	Due to (or as	a conseq	uence ot):						
ficate physics the	Physician/Medical			d									
eath certific attending p	n/M	IF FEMALE: 23b. Was deceden	nt pregnant		yes, outcome			□ Fatania avanga			2	3d. Date of	delivery
e death	sicia	in the past 12 1 ☐ Yes 2 l	□No	4	Pregnant a			☐ Ectopic pregnand ☐ Other (specify) _				Month	Day Year
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To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, is		29a. Certifier (Check only							ime, date and place opinion, death occu				
the H hin 24 the F	Medical	one)	Α	ã	and manner s			29c, Licens					onth, Day, Year)
To With	_	29b. Signature and	Julie of Certific	:1		~ 1 /	10	250 Elderi	20091		2/		2
/ / \		30. Name and add	ress of person	who comple	ted cause of	death (Iter	n 23a) (Type	Print)	V87 11			7/0	<i>l</i>
517	4**	1 ASNEE	m	AKI+	ANI.	283	55 8	A HIIM	YE Suit	TE 203	, B	ALID	MD 21209
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Registr	ar		S Y THE	2003	peru	~ /	a. 49	area.					

Amend #26, perverbal 6889 3/9/09 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27, Day 2009 Feb. **Physician** 23:38 **FATHOLLAHZADEH EZZAT** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Hospital 8. Date of Birth (Month, Day, Mar. 1, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ м 2 🚟 г Months Days Hours Mar. Iran 81 230-35-6265 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Midcal Everither This I be netitled. A once. 1 □Yes 2 □ No Director Gaithersburg Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20878 14224 Secluded Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robabeh Ipektchi Mahmmod Fathollahzadeh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, Md. 14240 Secluded Lane <u> Mitra Hashtroudi -</u> Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State National Mem. Park Mar. 2,2009 Falls Church, Va. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility National Funeral Home of Funeral Service Licensee 7482 Lee Highway Falls Church, Va. Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that clused the snock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cordiar MI. VUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MINUT Myoland Samularly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending ph for use as tl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) □Yes 2 □No s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 2 DAY 1 ☐ Yes 2 W No 1 □ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation Injury 1 Criatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 12:13 am D0068207 -M, O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Center MID 990

State Registrar

PUL

31. Date filed (Month, Day, Year)

32. Registrar's Signature

09-01	855
Siyon	Glenn

State of Maryland / Department of Health and Mental Hygiene 2009 0706 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Si Yon Isiah Glenn Physician/ Month Day March 5, 2009 1122 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) St.Agnes Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Min 83-100 Director Country) W 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No 28a-f show notified at once, 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 -1 D 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 1 Never Married Married 2 1/No Yes Yes 2 No specify: Divorced f Yes, Give Year δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 fan it. Pages I and 2 should be filed witnin artment of Health and Mental Hygiene. ortant: If item 27 is marked other tha ry or other traumatic event, the Medis ry or other traumatic event, 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) riscoe DRITHER Be 16 m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 161 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Cremation portant; Department Other Specify 21. Signate re of F 22. Name and Address of Fac Approximate Interval Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and e. List only one cause on each line. (Medica) Death Sudden unexplained death in infancy (SUDI) iate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit #1 per ME g890 4/22/09 Physician/Medical XUNPENDED **AMENDED** g891 5/18/09 TT 23a,27,28a-f,perME, Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Year Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Yes 2 X No Natural Pendina 3/5/09 Fd 10:30 Fd a m Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9 South Hilton St 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide house Baltimore, MD Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number t March 6, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCMF 2006**

Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	•		ficate of I		i wentai ny	_	2009	070	62
	Physici	an	Decedent's Name (First, Middle, Last	•	-wigh				2. Date of D Month		Day Year	3. Time of Deat 7:45 A.	
	/Medic	cal	4a. Facility Name (If not institution, give	Gustav Gast	LICII		lb. City, Town, or	Location of De	<u> March</u>	_	2009 4c. County of Death		
1	Examin	ier	Stella Maris H				Timoniu				Baltimon		
E	Funeral Director		5. Social Security Number 6. S	~	(In yrs. last birt		If Under 1 Year Months Days			irth ay, Yea	9 Birth	nplace <i>(State or For</i> Intry) 13ylvania	eign
	pu v		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	tion					10d. Inside City Lir	nits
	e Maryla 8a-f shov	Director	Maryland Baltimo			dwin						1 ☐ Yes 2√2	
	ath with the 23a or 2	ral Dire	10e. Street and Number 4600 Langshire				10f. Zip Code 21(of	Citizen of What Co. Inited Sta America		
900	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exemirer must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces? 1, ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1	s Decedent of H es, specify Cuba	ispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)		Spoony.	, etc. nite	
Maryland 21215-0036	in 72 ho n "natu Aedical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Deceder (Give kir life. DC	nt's Usual Occup nd of work done of NOT use retired	ation during most of w d)	vorking	16b.	. Kind of Business/li	ndustry	
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pu	0 7	Be (17. Father's Name (First, Middle, Last)						ame (First, Middle				
yla	2 should be i and Mental Is marked o raumatic eve	မ	Gustav Henry						D. Heffl				
	nd 2 salth an 27 ls		19a. Informant's Name/Relationship (Mrs. Elfriede Gas		٤ 4	4600	Langshi	re Road	Baldwin	, M	ty or Town, State, Z aryland 2	21013	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		g ₁ Fu	ion (Name of tory or other place Seral Berair	20	ch 9,	 F	.Location - City or 1 Orest Hil	l, Maryla	and
Ball	permit. Page Department of Important; If any Injury or once.		21. Signature of F. neral Service Licer	ispe		Feat	Vame and Addre Ceful Al 2325 Yor	ss of Facility ternati k Road	ves Fune Timoni	ral um,	&Cremati Maryland	on Ctr.,	2.A
5	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	one cause on each line a. COLON CA Due to (or as a	NCER consequence	of):	the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Betweer Onset and Death	1
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rds, P.	w requires that been signed to should be deta	þ	Part II. Other significant conditions of	contributing to death but	t not resulting in	n the und	erlying cause giv	en in Part I.			co use contribute to	100	
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	To the I within 2 To the I complete	Me	29b. Signature and title of certifier	CKNY			29c. Licens	e number 6792	_	29d.	Date signed (Month	n, Day, Year)	
15	MIV		30. Name and did so of a rson who	completed cause of de	ath (Item 23a)	(Type, Pr	int)				/		
10	45		31. Date filed (Month, Day, Year)_	32. Cgistra	ULANEY 's Signature	VAL	LEY RD.	TIMONI	UM, MD 2	109	3		
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DHMH 17 Rev 1/2001

MARCH 7, 2009 7:45 a.m.

HENRY GASTRICH

			for State Registrar	Otato or Maryit	Certific	cate of Deal	th	Reg. N	2009	07063
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	/Medic	al	4a. Facility Name (If not institution, g	E. Giles	4h. (City, Town, or Location		arch a	c. County of Death	12,3014
	Examin	er		ins Bayvieu			Baltimo		N/A	
	Funeral Director		218-14-7162	Sex 7. Age (In y 1	ro. raot Bir tiriday/		der 24 Hrs. 8. Da rs Min. (M OCT	te of Birth fonth, Day, Yea 11,19	9. Birthp Cour	place (State or Foreign htry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Location				1	0d. Inside City Limits
	Mary a-f sh	ctor	MD N/A	В	ALTIMORE					1 AYes 2 □ No
	th with the 23a or 28 Ist be not	Funeral Director	10e. Street and Number 5425 OMAHA AVE			. Zip Code 21206		US	Citizen of What Cour	ntry?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other fraumatic event, the Medical Examination to the fraumatic event, the Medical Examinations.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:	1 □ Y€	ecedent of Hispanic specify Cuban, Mex es 2 No Spec			Эреспу.	etc. WHITE
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Ba	permit. Departr Importa any Inju		21. Signature of Funeral Service Lic	A See		5 BELAIR			MD 21206	
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O. Box	eath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. tf yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 Ecto	pic pregnancy er (specify)			23d. Date of deliv Month	ery Day Year
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not 4 Homicide determine	d building, etc. (Sp			C	ity or Town, Sta		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my aminer: On the basis of exan and manner stated.	knowledge, death occu mination and/or investig	urred at the time, dat ation, in my opinion,	te and place, and do death occurred at	ue to the cause the time, date a	e(s) and manner as and place, and due t	stated. o the cause(s)
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	6		30. Name and address of person who Jodi Renne	o completed cause of death ((Item 23a) (Type, Print)	astern	Avenu	le Bal	Itimore	marylan
	Sta	ite	31. Date filed (Month, Day, Year)	32 Aegistrar's Si	ignatur how	7		- 1-4		21224
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 9:30 A M March Ozen Heuscher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9105 Gardenia Road Baltimore Nottingham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 216-62-7574 2/3/1945 64 Director Turkey Usual Residence of Decedent the Maryland 10c. City. Town or Location show 10a State 10b. County 10d. Inside City Limits Ħ event, the Medical Examiner must be notified Director 1 ☐ Yes 2 X No 28a-f MD Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 9105 Gardenia Road U.S.A. Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Specify: White 1 ☐ Yes 2 🛣 No Specify. þ 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental Omar Alir Serife Tosun ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Heuscher/ Son 9105 Gardenia Road, Nottingham, MD 21236 27 if item 27 or other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any Injury or once. Anatomy Gifts Registry 3/4/2009 Hanover, Maryland 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral S. rvic , icensee BOF 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YEARS HUNTINGTON disease or condition resulting in death) DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Acciden completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20027985 03-04-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William H. Silverman, MD 1201 Seven Locks Rd, Ste 111, Rockville, MD 20854 31. Date filed (Month, Day, Year) 32. Restrar's Signature State MARO 9 2009 Registrar

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 9:15PM Grace March 2000 Ita 03 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Battimore Park Health & Rehab Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Baltimore 1 ☐ Yes 2 No by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 656 LUCKY Leaf 2028 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care College (1-4or 5+) Elementary/Secondary (0-12) Assistant 10th grade 18-Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Dutt Trank Fisher ဂ္ 19b. Mailing Address (Street and Number or Rural Route Nu ber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) Circle Baltimore MD 21228 rolanda Gross 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State 03 07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility augher C. Greene Funoral SVCS rdallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or hear, failure. List only one cause on each line. cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque wire of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physlclan: The law requires that the death certificate be exec e attending physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗆 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 poleted cause of death (III m 23a) (Type, Print 30. Name and address of person who com 228 mora

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** tarole 2009 March 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Opuntry) **Funeral** Months Days Hours 1 M 2□ F Director a Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at Baltimore 1 es 2 □ No Funeral Director ma. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 1 Pes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Newer Married 2 Married 21215-0036 2 N6 1 🗆 Yes þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12H 7 is marked other traumatic event, II Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental marie dnee ပ 19b. Mail Address (Street and Number or Rural Route Number, City or Town, St. e, Zip Code) 19a. Informant's Name/Relationship , Rd. Wordlaun. 311 . Hollina 3 Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Wwd awn Cer 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 nent of h 1 Deurial 2 □ Cremation 3 Removal from State Woodlawn 4 ☐ Donation S ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Licensee 23a. Part / E / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediat - Cruse (Final disease of ondition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. detached 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, signe be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law autopsy Division of Vital 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. and r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 1 🗆 Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
March 6, 2009 29c. License number 29b. Signature and little of certifier 030433

DHMH 17 Bev 1/2001

State Registrar 6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles Atrell Ballinione Md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item20b,25 per fn/dr., g889,03/05/09dhb,#23aPtI Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:34 PM Robert Lee, Ing 2009 February /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Harbor Hospita 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**№** M 2□ F 86 25,1923 Maryland Director <u>216-</u>16-6475 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 217 No Director Linthicum Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 306 John Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No IfYes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 T Married Specify: White Baltimore, Maryland 21215-0036 1 ∐Yes 2 🕱 No Specify. þ 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, It Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Plant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Faber Charles A. Inglis ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 John Avenue; Linthicum, Maryland 21090 <u>Kathleen Inglis</u> Wife Date Cini 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/08/2009 Arlington, Virginia Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign ture of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Franta ef Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last D BY MEDICAL EXAMINER Directo (or se a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): CERTIFIC Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No Division of Vital Records. P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 UN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 3 🖺 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide within 24 hours a To the Funeral L 1 Fritfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanover 32. Registrar's Signature

			1 - For State Registrar	State of M	aryland / Dep		Health and N	Mental Hyg	iene 2009	07068
	Physic	ian	1. Decedent's Name (First, Midd					2. Date of Death	Day Year	3. Time of Death
	/Medi Exami	ical	4a. Facility Name (If not institution	bn, give street and number)	Jei	4b. City, Town, o	or Location of Death	March	4. 205 4c. County of Deat	9 25 AM
d	LAGIII	1161	The Johns Hopkin	s Hospital	•	Baltimore	City		N/	Α
	Funeral Director		5. Social Security Number 043-26-2141 Usual Residence of Decedent	6. Sex 1 M 2 □ F	ge (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 25,	Year) Cou	nplace (State or Foreign intry) WICh, CT.
	Maryland a-f show fied at	tor	10a. State 10b. Count	N/A	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ŽŽNo
	or 28.	Director	10e. Street and Number			10f. Zip-Code		10	g. Citizen of What Cou	intry?
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036	ages I and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. And I health and Mental Hygiene. I hear 21 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2X Ma 3 Widowed 4 Divorce	If Voc Givo -	No IOT Call	was Decement of the lift Yes, specify Cubin 1 ☐ Yes 2 1 No	dispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc. hite
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	and 2 lealth a m 27 is ner trau		Mrs. Frances A	. Jennings (W	ife) 400	Symphony	Circle			ley,MD.21030
more	rages in nent of H int: if Iter iny or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other		20b. Place of Dispo cemetery, cred Evans Fun			h 06,	0c. Location - City or 1	own, State
Baltimore,	Department of Important: If any Injury or once.		21. Signature of Funeral Service		Per Per	2. Name and Addre	ss of Facility Lternative	eş Funera	al&Crematio	on Ctr.,P.A.
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	hysician		Immediate Cause (Final disease or condition	only one cause in each lin	monia					Interval Between Onset and Death
	Medical xaminer		resulting in death)	Due to (or as	a consequence of):	اامم	1	Cityo		
3	sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or).	CCII	rury	can	0/	· · · · · · · · · · · · · · · · · · ·
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Hec F	2 s	Completed						24a. Was an autopsy performe	prior to co	ppsy findings available ompletion of cause of
of Vital	s certifica director,	Be	25. Was case referred to medical examiner?	Hoopital:		2 DOA Othe	26. Place of Death	(Check only one)		
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VISION	death. stor: Affe iy the fun	ertification:	1 Natural 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation			? Yes 2 □ No		. ,	
5 5	# ¥ ⊑	Certifi	4 Homicide determ	building, etc				City or Town, S		
e Hospi	within 24 hours a To the Funeral D completely filled	Medical	29a. Certifier 1 Certifyir (check only one) 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or inv	occurred at the timestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due	stated. to the cause(s)
10 10	vithi Com	Ž	29b. Signature and title dicertifie	M: Mi		29c. License	number	7 1	. Date signed (Month,	Day, Year)
2	1		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type, F	Print)	(11/25	lamb W-1	larch o	200
	Sta	te	31. Date filed (Month Day Year)	32. egistral	's Signature	and I	600 N	iorth Wolfe	e St, Baltimoi	e, MD, 21287
	Registr	:12	יייותה	LUUS KANDE	~ p. 190					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per very person of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Virginia Keller Mar 4, 2009 1:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Assisted Living Lutherville **Baltimore** Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 KF 213.32.5614 72 Director MD Apr 10, 1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprise International any injury or other traumatic event, Ite Medical Exprise International any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Howard Elkridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6389 Beechfield Avenue 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) banker financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles E. Selby Myrl Clagett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Keller - son 117 Central Avenue Brunswick, MD 21716 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Dispesition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Domation 5 Dother (Specify) All County Cremation Services. Mar 05, 2009 Sykesville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility hundella & Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City. MD 21043 1100535 Approximate Interval Between Onset and Death art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 s autopsy perform 1 ☐ Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To

sion of Vital Records,

Hospital or Attending Physician: The learns after death. Funeral Director: After this certificate h. filled in by the To the ... To the ... To the Funeral D'

Other: 4 Nursing Home Assisted Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day,

License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of

32

State Registrar

Registrar's Signature

			For	State of Ma	aryland		artment of I		Mental Hy	gien	е	
			State Registrar			Ce	ertificate of	Death		Reg. N	° 2000	9. 07076
	Physicia	an	1. Decedent's Name (First, Middle,	KLACI	K				2. Date of De Month	D.	ay Year	3. Time of Death (
	/Medic	al	MICHAEL 4a, Facility Name (If not institution,	7	1		Ab City Town o	or Location of Deat	03	0	7 09 c. County of Deat	
and the second	Examin	er	Boltimore WAS	1 1 11/1	den	100	6 Glen	Burne			nmp.	Americal
	Funeral		5. Social Security Number 6	. Sex / 7. Age	(In yrs. la	st birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th av. Year	9. Bir	thplace (State or Foreign
	Director		212-42-2604	1 🛛 M / 2 □ F	65	Yrs.	IVIOITIIIS Days	Tiours Will.	11/09/			yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
	Maryl f sho	tor	Maryland Anne Ar	rundel	Gle	n Bur	nie					1 □Yes 2 ☑ No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exa., in a must be notified at	irec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?
	th with	Funeral Director	205 Packard Avenue			21061					U.S.A.	
	r dea	une	11. Marital Status	12. Was Decedent E Armed Forces?		. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))~	14. Race - Ame Black, White	erican Indian, e, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	d 1∭XYes 2 □ N If Yes, Give V Year or Dates:	₀ 7ietna	am.	1 ☐ Yes 2X No	Specify:			Specify: W	Mite
2121	tural'	ed k	15. Decedent's			16a. Dec	edent's Usual Occu	pation		16b.	Kind of Business	
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	filed within Hygiene. other than " ent, it. Me	Completed	12			Engineer			(5)	Verizon		
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Z		욘	Michael P. Klaci 19a. Informant's Name/Relationship					rie Carrigan ural Route Number, City or Town, State, Zip Code)			Zin Code)	
_	d 2 s th ar 7 is trau	1	Sharon E. Klacik				Packard A					
ē,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition	(20b. Pla		position (Name of ematory or other pla		Date		Location - City or	
Baltimore,	Page: ient o nt; If ry or		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Crematory	i i	19/2009	Bali	timore	Maryland
<u>=</u>	mit. partm porta y Inju		21. Signature of Funeral Service Li		Day		22. Name and Addr					
m	B I De	1 1	1 2/6			2	1407 old	Eastern	Avenue,	Es	sex, Mar	yland 21221
			23a. Part 1. Enter the disease, or co shock or heart failure. List or	omplications that caused nly one cause on each lir	the death	. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	10 01 71	14				
	_xaiiiiio.	ē	Sequentially list conditions,	b. CAK	e consecu	ange off:	10 PATH	1)				
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8760,	icate be executed physician and the burial-transit	edical		d								
Θ	ertifica ing ph	Med	IF FEMALE:	-	_		- VS		-			
ô	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗀 Fetal	death 3	Ectopic pregnan	су		i	23d. Date of de Month	elivery Day Year
P.O. Box		Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown				death 5 ☐ Other (specify)					
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Division of Vital Records,		BeC	25. Was case referred to medical examiner?			-,-		26. Place of De	ath (Check only			_
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		a C	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	n 24 h	edical	(Check only 2 ☐ Medical E one)	xaminer: On the basis o and manner sta		tion and/or	investigation, in my	opinion, death occ	curred at the time			
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,	DTIV		30. Name and address of person w	ho completed cause of d	leath (Item R AL T	23a) (Typ	e, Print) E WASHII	NETON N	EDICAL	0	GNIER	
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MARO 92009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 02-12-2009 **Physician** Marion L. Krim 0135 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-30-1926 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🛛 F 82 Director 161-22-2667 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the MacKeal Eventme trans be rectified at once. 1 ☐ Yes 2 X No Director Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1500 Duncannon Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify Specify: White <u>6</u> 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental Tekla Adam Lisowski ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7246 Gunpowder Rd Middle River, MD 21220 Barbara J. Krim (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02-16-2009 Bel Air, MD BelAir Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Inc. 610 W. MacPhail Rd BelAir, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Spinal Cord Shock and Hypotension Immediate Cause (Final **Physician** disease or condition resulting in death) Due for as a consequence of): Degenerative Spine Disease /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit OVED OF EDICINA PUNT Due to (or as a consequence P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Hypertensive Atherosclerotic Cardiovascular Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Cerebral Infarction; Dementia 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attends after death filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KENNETH ROY MAAG /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 10/16/1925 9. Birthplace (State or Foreign Sex X M 2 □ F 7. Age (In vrs. last birthday **Funeral** Social Security Numbe Days Months Hours Min. Director PENNSYLVANIA 177-20-8021 Usual Residence of Decedent 83 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Exemitive count be notified at Director 1 ☐ Yes 2X No BALTIMORE PARKVILLE 28a-f MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 "natural", or items 23a 1818 REDWOOD AVENUE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ty⊟Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify φ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4nr 5+) WESTINGHOUSE + YEARS ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H å FRED MAAG JANETTE KIRSTIN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau JOAN MAAG/WIFE 1818 REDWOOD AVENUE PARKVILLE, MD 21234 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/9/2009 CATONSVILLE, MD THE JOHNSON FUNERAL HOME, CREMATORY, INC. 21. Sign ture of Funeral Service Licensee MO1139 22. Name and Address of Facility Ras 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 ng physician as the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ER Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of eath 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Baltimore, Maryland 21215-0036 Box 68760 Ö σ. Records, Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, of Division certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person v pleted case of death (Item 23a) (Type, Print) KERITH 1.D. 5601 Local
32. Pegistrar's Signature, 1.D PAVENBUND BALTIMORE, MD 31. Date filed (Month, Day, Year) State MARO Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01849 State of Maryland / Department of Health and Mental Hygiene Matthew Samuel Markle 2009 07073 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0706 hrs Matthew March 5, 2009 Samuel **Medical Examiner** Markle c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Route 155 and Interstate 95 Hayre de Grace 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Euneral** Foreign Country Days Hours Min 208-60-6987 10-30-1971 Director 37 1 XM Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10b. County Yes 2 X No Cecil Conowingo s 23a or 28a-f show a Maryland after death with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 21918 10e, Street and Number U.S.A. 844 Ragan Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status , or items 2 r must be r White etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 XMarried White 2 X No Yes Yes 2 X No specify: If You Give Year 3 Widowed Divorced "natural", ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6b. King of Business/Industry 15. Decedent's Education (Specify only highest grade completed) more, MD 21215-0036
Pages I and 2 should be filed within 72 hours not of Health and Mental Hygiene. Completed Elementary/Secondary (0-12) College (1-4 or 5+) Cabinet Maker Woodworking fant: If item 27 is marked other than or other traumatic event. the Medical 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Lamontagne William Markle J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ို 844 Ragan Road Conowingo, Maryland 19380 Maria Markle - Wife timore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 X Removal from State 3-9-2009 West Chester, & Co. Ferris fment o Donation 5 Other Specify 22. Name and Address of Facility 21. Signal of Funeral Service Licenses Joseph N. Zannino 263 S. Conkling St. Balto. Md. 21224 Part I. Enter the disease roo iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List onlyne ause o each line /Medical Death a. Neck Injury Immediate Cause (Final disease) aminer or condition resulting in death Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 ✔ No 3 Probably 4 Unknown ٦ Completed Records, 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy has 2 st death? performed? 2 No ✔ Yes 2 No 1 V Yes page certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: Residence 6 V Other: Scene ER/Outpatient 3 Nursing Home 5 Inpatient 2 After this 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury 27. Manner of Death Driver in motor vehicle roll-over Certification Mar 5, 2009 0655 hrs Yes 2 V No Natural Pending 2 🗸 Accident Investigation

or Attending Physician: Division of Vital hours after death. Funeral Director: etely filled in by the Hospital 24 To the

> 30. Name and address of person who completed cause of death (Item 23a) Carol Alian, MD 31. Date filed (Mo) State Registra

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one)

Medical

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Could not be

determined

92009

. Registrar's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State) Route 155 and Interstate 95 , Havre de Grace , MD

March 5, 2009

(Specify) Interstate/Express

and manner stated

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 4a per doc g889 3-9-09 vt.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:49 P M McGowan 2009 Renee 19, February /Medical 4a. Facility Name (If not institution, give street and number)
—FIEGETICK Memorial Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 18-92-748 1 □ M 2 12 F Yrs 26 **Director** 196 HNHAPOLIS Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other treumatic event, the Madical Examiner must be redified at engine. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Ves 2 No PENERICI Director MD. FRENERIC 10g. Citizen of What Country? 10e. Street and Number 4.5. 2 i 703 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DIJABLES Elementary/Secondary (0-12) College (1-4or 5+) DISALLEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GOWANY ဥ 19a. Informant's Name/Relationship (Type. Print(S(STER)) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMBERWOLF PREDERIER MO 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 d Burial 2 ☐ Cremation 3 ☐ Removal from State CREST Can HXMAN-LIS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARI MINS FUNERAL HOME 21. Signature of Funeral Service Licensee SULTA MS. 2/701 110 W. FRED 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardom disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran P.O. Box 68760,€ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 NO within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medicel examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buyshman Lan Tredak HZE 31. Date filed (Month, Da Registrar's Signatur 9 State Registrar

		for State Registrar	State o	f Marylan		artment rtificate			Mental Hy	/giene	2009	9 07	075
		Decedent's Name (First, Middle,	Last)						2. Date of De	eath		3. Time	of Death
Physicia /Medic		Stella V. McFau	.1						Month	Z 5	2 00 S		AM
Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, To	own, or Loca	ation of Death		4c.	County of De	ath	
ý		FRANKLIN Squai	= HOSP			,	sedo	-				Timor	
Funeral Director		5. Social Security Number 216–24–4395	5. Sex 1 □ M 2 💢 F	7. Age (In yrs. 80	last birthday) Yrs.			Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D Feb. 2	ay, Year)		irthplace (State Country) irginia	or Foreign
pu »		Usual Residence of Decedent 10a, State 10b, County		100 Cit	ty, Town or Lo	ocation						10d. Inside (City Limits
shov	ō		o		ly, TOWIT OF LC	ocation							s 2X No
28a-f	Director	Maryland B 10e. Street and Number	altimore			10f. Zip C		undalk		10a. Citi:	zen of What 0	Country?	
with Sa or	Ö	8012 Gray Haven	Road					222			ted Sta		
ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decede			pecify Yes or N Rican, etc.)		14. Race - An	nerican Indian,	_
or ite	Fu.	1 ☐ Never Married 2 ☐ Marrie	Armed Fo d 1 ☐ Yes If Yes, Gi	2x7No		1 ☐ Yes 2[pecify:	o Rican, etc.)	ĺ	Black, Wh	ite, etc.	
ural",	d by	3 XWidowed 4 ☐ Divorced	Year or D	ates:								ite	
"natı	Completed	15. Decedent's (Specify only highest	Education grade completed)		1 (Give	dent's Usual kind of work DO NOT use	done during	g most of work	king	16b. Kir	nd of Busines	s/Industry	
withir ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	,				Own Ho		
filed Hygi other ent,	Be C	12 years 17. Father's Name (First, Middle, La	ast)		1 IIOIII	emaker		Mother's Nam	ne (First, Middle	e, Maiden		me	
lld be fenta rked ric ev	To B	Honny Colum						C =	Jack	son			
shou s ma	Г	Henry Colvin 19a. Informant's Name/Relationship	p (Type. Print)		19b. Maili	ng Address (Street and I	Carrie Number or Ru	ral Route Numi	ber, City o	r Town, State	, Zip Code)	
and 2 ealth n 27 i		Vanessa Kirtz	(Daught						ne Driv			ort, LA	7112
ges 1 t of H If iter or oth		20a. Method of Disposition XIII Burial 2 ☐ Cremation 3	B □ Removal from	State 20b. F	Place of Dispo cemetery, cre	osition (Name matory or oth	e of er place)		Date	20c. Lo	cation - City o	or Town, State	
t. Pag tmen tant; ijury		4 □ Donation 5 □ Other (Spe	ecify)		Lly Hi	ll Mem	. Gdns	s. 3/1	0/2009	Mid		ver, Md	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee		1	Duda-Ri 7922 W:	uck Fi ise Ar	uneral venue	Home of Dundal	f Dun k. Ma	dalk,	Inc. 21222	
		23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that	caused the deat								Approxima Interval Bo	etween
Physician		Immediate Cause (Final disease or condition	Lui	_	ancel	~						Onset and	i Death
/Medical Examiner		resulting in death)	Due to	(or s a conseq	uence of):								
Lxummor	¥	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	mence of).							-	
nsit	Examiner	Cause. Enter Underlying	Ducto	(or as a conseq	de1100 017.								
be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):								
ficate be physicial sthe bur	ical		d										
ing ph	Physician/Med	IF FEMALE:											
leath certific attending p	ian/l	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2 Teta	al death 3	Ectopic pre				2	23d. Date of o	lelivery Day	Year
at the de by the a tached f	ysic	1 □Yes 2 ☑No 9 □ Unknown	4 □ Preg 9 □ Unki	nant at time of one	death 5	Other (spec	cify)		-			ŕ	
that t		Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	inderlying cau	ıse given in	Part I.	23e. Did	tobacco u	se contribute	to the cause of	death?
quires that n signed I ild be det	d by								12	Yes 2	□ No 3□	Probably 4 □] Unknown
sw requir s been s s should I	Completed								24a. Wa		24b. Were	autopsy finding	s available
The law ate has	E O								perf	opsy ormed? 2 No	death'	o completion of ? es 2 □ No	cause or
sician; The Is certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?					26.	Place of Dea	th (Check only				
iding Physician; th. After this certifical funeral director,		1 Yes 2 No		Inpatient 2	,		Other: 4	□ Nursing H	ome 5 Res	sidence 6	Other (Sp	pecify)	
ling P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury oth, Day, Year)	28b. Time o Injury	of 280	c. Injury at Work?	o C No	28d. Describe	how injury	y occurred		
death death stor: / the i	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	the l	of Injury - At h	ome farm st		1 □Yes	2 🗀 140	28f. Location	(Street an	d Number or	Rural Route Nu	mher
after after Direct	Certification: To	4 ☐ Homicide determin	build	e of Injury - At he ing, etc. <i>(Speci</i>	fy)	, , , , , , , , , , , , , , , , , , , ,			City or To	wn, State))	10/01/10010	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	(Check only 2 Medical E	Physician: To th	pasis of examina	owledge, dea ation and/or in	th occurred a	t the time, c	date and place on, death occu	e, and due to the	e cause(s) e, date and	and manner place, and d	as stated. ue to the cause	(s)
o the vithin 2 o the omple	Meo	29b. Signaturerand title of certifier	and mar	nner stated.		29c.	License nur	mber		29d. Dat	e signed (Mo	nth, Day, Year)	
FSFO		K D mo	,			7	0630	154		FEB.	25,	2009	
				se of death (Iter	m 23a) (Type,	Print)					(
		MAND CINA, MD,	9000 F	ronkin So	quare D.	rive, Ba	Himan	e, Mo	2123	1			
Sta		31. Date filed (Month, Day, Year)	9 000 f	gistrar's Signa	ature.	barker	7						
Registr	वा	MAN U 9	CARA V	Marie	, T.								

DHMH 17 Rev 1/2001

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Division of Vital Records, P.O. Box 68760,

			1 - For State of Maryland		artment of H		and M		gien Reg. N	/ 1111	9 07076
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Billie Jean Nicholson					Month March	5	ay Ye ai 2009	1:10 P M
1	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	of Death		40	c. County of De	
7			Gilchrist Hospice		Towson					Balti	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, <i>Year</i>	9. B	irthplace (State or Foreign Country)
	Director		24524025527	Yrs.				12/20/	1928	8 N C	rth Carolina
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation						10d. Inside City Limits
	Maryl f sho	ō	MD Baltimore Bal	timor	0						1 □Yes 2 ☑ No
	the l	rec	10e. Street and Number	CIMOL	10f. Zip Code				10g. C	itizen of What C	Country?
	3a ol	Funeral Director	2610 Windsor Road		21234	ļ			Ţ	J.S.A.	
	death ms 2	ner	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Vas Decedent of Hi f Yes, specify Cuba		gin? (Spe	cify Yes or No		14. Race - Am	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be notified at once.		1 Never Married 2 Married 1 Yes, Give		fYes, specify Cuba 1 ∐Yes 2 🛣 No	in, Mexican Specify:		Rican, etc.)		Black, Wh	•
0	hours tural'	Completed by	3 X Widowed 4 □ Divorced Year or Dates:	160 Dogg	dont's Houst Ossus	ntion		1	16h k		
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212	with jiene r thau	E O	Elementary/Secondary (0-12) College (1-4or 5+)		retary	,			Ва	anking	
ğ	e filectal Hyg	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name	(First, Middle,	Maide	n Surname)	
Baltimore, Maryland 21215-0036	uld be Menta rked atic en	To E	Robert Cavney			E13	la S	towe			
lar	2 sho and is ma auma		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a						Zip Code)
≥,	and and marking markin		Leah Nicholson/ Daughter		Windsor F	<u>.</u>		· · · · · · · · · · · · · · · · · · ·			
ore.	ges 1 t of H if ite or oth		20b. Pla 20b. Pla 1 □ Burial 2 □ Cremation 3 □ Removal from State	ce of Dispo netery, cren	sition (Name of natory or other place			ate		ocation - City o	
턡	t. Pag tmen tant: tant:		4 🖫 Donation 5 □ Other (Specify) Ana	-	fts Registr		3/6/2	009	Har	nover, I	Maryland
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Licensee	i	. Name and Addres		And			s Regisanover,	
П			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	VTIA							Onset and Death
Į	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of):							7-77
		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	noo of):							
	rted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rice oi);							1
	execun and al-tra	Examiner	that initiated events resulting in death) Last C	nce of):							
8760,	ficate be executed physician and s the burial-transit	dicall	ď								
9	tificat ig phy as th	edi									
Box	leath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy	,				23d. Date of de	elivery
<u>.</u>	e dea the att	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of dea		Other (specify)					Month	Day Year
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ds,	aw requires that s been signed I s should be det		Part II. Other significant conditions contributing to death but not result DIABETES	ng m trie ur	idenying cause give	en in Part I,			res 2		to the cause of death? Probably 4 Unknown
Ö	/ requ	etec	Comp Aller Company					1			
Division of Vital Records,		Completed by	Emingsema						sy rmęd?	prior to death?	
ita	an: rtifica tor, p	Be C	25. Was case referred to medical			26. Place	of Death	1 ☐ Yes (Check only o	2 No	o 1 □Ye	s 2□No
+	nysic nis ce direc		examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatien	t 3 DOA Othe					6 MOther (Sp	ecify) HOSFICE
0	ng Pt fter th	:uc	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2	8b. Time of Injury	28c. Injury Work	at		8d. Describe h	_		1 William
sio	tendi eath. or: A	cati	2 Accident investigation			/es 2□N	No				
<u> </u>	or Attending Physician: The I after death. Director: After this certificate ha I in by the funeral director, page	Certification: To	4 Homicide 4 Homicide 4 See Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		2	8f. Location (S City or Tou			Rural Route Number,
	spital nours neral y fillec		29a. Certifier 1 Certifying Physician: To the best of my knowl	edge, death	occurred at the tim	ne, date an	d place, a	nd due to the	cause(s	s) and manner a	as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or inv	estigation, in my or	oinion, dea	th occurre	d at the time,	date an	nd place, and du	e to the cause(s)
	vit vit	Σ	29b. Signature and title of certifier		29c. License		3			ate signed (Mon	
			1 - 60/12			439	>		MA	RCH 5	, 2009
I	1		30. Name and address of person who completed cause of death (Item 2 DANIEUE DEBERMAN, MD 6565	5NO	HAPLIS S	T, 84	177-2	09 B	SALT	TMORE, M	1 21204
	Stat Registra		31. Date filed (Month, Day; Year) 32. Poistra's Signatu MARO 92009	1. 4	and						
				7.7							

DHMH 17 Rev 1/2001

MARCH 5, 2009

Nicholson, Billie

		•	For State Registrar	State of Ma		epartment of F C <i>ertificate of</i>			eg. No. 200	9 07077
	Physici /Medic		1. Decedent's Name (First, Middle GEORGE W	, Last) NOAH	JR			2. Date of Deal Month	th Day Yea 04 200	
	Examin Funeral Director	er	4a. Facility Name (If not institution BATIMONE REHA	BILITATIONE	TGNOFO CA e (In yrs. last birth 64 Yr	day) If Under 1 Year	r Location of Death NORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 23	9. B	ath /A irrhplace (State or Foreign Country) LORIDA
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	Maryla -f sho	tor		/A		TIMORE				1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?
	ath wil	ral	718 S. CONK			212			U.S	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventual.	by Funeral	11. Marital Status1 X Never Married 2 ☐ Marrie3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? ed 1 X Yes 2 □ N If Yes, Give Year or Dates: 1	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 3√□ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Prican, etc.)	Black, Wh	
21215-0036	72 hour "natural"	leted k	15. Decedent (Specify only highes	s Education	16a. D	ecedent's Usual Occup Give kind of work done	during most of work	ring	16b. Kind of Busines	HITE s/Industry
12121	ed within lygiene. her than '	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5-	DEP	ife. DO NOT use retired T. OF THE	INTERI		J.S. GOV	ERNMENT
and	d be fill ental F	o Be	17. Father's Name (First, Middle, L GEORGE WII	LLIAM SR.			18. Mother's Nam		Maiden Surname) ARY REIC	тррт
aryl	2 should be and Mental is marked of aumatic ev	10	19a. Informant's Name/Relationsh		19b. N	ا Mailing Address (Street				
Ž,	and 2 ealth a n 27 is		<u>`</u>	FRIEND		S. CONKI			<u>.</u>	
Baltimore, Maryland	Z :: e		20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State ecify)	1	Disposition (Name of crematory or other place) W CREMATO	and the second second		20c. Location - City o	Town, State E, MARYLAND
Balt	permit. P Departm Importar any Inju		21. Signature of Funeral Service L	icensee		22. Name and Addre	ss of Facility ZETLER CONKLING	INC. FU	JNERAL H	
-	ifficate be executed physician and g physician and g the burial-transit	al Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate for the conditions of the condition	a. LUNG Due to (or as a	e.	EER				Inierval Between Onset and Death
P.O. Box 68760,	t the death cert by the attendin ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of d Month	elivery Day Year
	quires than n signed uld be det	þ	Part II. Other significant condition	ns contributing to death bu	t not resulting in th	ne underlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
II Reco	: The law requir cate has been si page 2 should b	Completed						24a. Was at autops perform	y prior to ned? death?	autopsy findings available completion of cause of
Division of Vital Records,	Hospital or Attending Physician: The 42 hours atter death. Euneral Director: After this certificate telly filled in by the funeral director, pag	ion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	nt 2 ER/Outp y 28b. Tin (Year) Inju	ne of 28c. Injur	y at k?	ome 5 Reside	e) ence 6 □Other <i>(Sp</i> ew injury occurred	necify)
Divisio	tal or Attencrs after death al Director; ed in by the	Certification:	2 Accident investiga 3 Suicide 6 Could n 4 Homicide determin	- L L -	ry - At home, farm . <i>(Specify)</i>	M	Yes 2 □No	28f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of ixaminer: On the basis of and manner sta	examination and/	death occurred at the ti or investigation, in my o	me, date and place, ppinion, death occur	and due to the c red at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the To the company of the	Ź	29b. Signature and title of certifier	a, md		29c. Licens	e number	2	9d. Date signed (Mor	nth, Day, Year)
•		-	30. Name and address of person w	/ho completed cause of de	eath (Item 23a) (Ti				51 4 1 4	v /
			HONAS S MILLE	R. M. 3900	LOCH	RAVEN B	COULEVAR	O. BALTI	nost, M	921218
	Sta Registr	te ar	30. Name and address of person was a mile of the second of	2009 32. Registra	r's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:10 Edith M. O'Hara 200 Chr /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death unty of Death **Examiner** atonsvi 8. Date of Birth (Month, Day, Year) Jan. 24, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 □ M 2 X F Hours Country) Maryland 80 212-26-4159 **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Director 1 ☐Yes 2 ☑ No Maryland Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane #113 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: β 3 → Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If item 27 is marked other tim any Injury or other traumatic execution. Senior Office Clerk Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Keller Alice Nicholson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy O'Hara 402 Thackery Avenue: Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) Lorraine Park 3/12/2009 Woodlawn, Maryland 4 Donation 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. ature of uneral Service Lice 630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 Vascu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) faw requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending p as IF FEMALE: nse yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months2 1 ☐ Yes 2 ☐ No Day Year P.0. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate 2 1 1 ☐Yes 2 ☐No □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Narsing Home 5 Residence 6 Other (Specify) 1∐ Yes 2LNő 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Maid

hoice

ieral Director: A filled in by the fu

2+1/a State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MARTINA PLUCCE MD 31. Date filed (Month, Day, Year)

MAR 0 9 2009

6 □Could not be

determined

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

300 WOST 9TH ST Registrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 ☐ Yes

29c. License number 046248

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 No

FX000Rin up 21701

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3/3/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01818 State of Maryland / Department of Health and Mental Hygiene Charles Herbert Robbins 009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0400 hrs March 4, 2009 **Medical Examiner** Charles Herbert Robbins 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 900 Block of Mayhew Inn Road Oakland Garrett 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director 212-48-0919 09/25/1947 Country) Kentucky 61 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h. County Yes 2 X No s 23a or 28a-f show e notified at once. or 28a-f show W. VA. Albright Preston the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Route 2, Box 273 A 26519 U.S.A. with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 Armed Forces? Never Married 2 Married 1X Yes or Pages I and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner in Yes 2 X No specify: White 4 X Divorced or Dates: Vietnam Specify: Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Baltimore, MD 21215-0036 Bethlehem Steel Welder 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Mae Gibson Lovell Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 Savannah Road, Baltimore, Maryland 21221 Sandra Pack (Daughter) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Department of Important: 1 injury or oth Holly Hill Mem. Gard. 03/10/2009 Baltimore, Maryland Donation 5 Other Specify. ^{22. Name and Address of Facility}
Bruzdziński Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Part I, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a Head and Neck Injuries diate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 3h Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Yes 2 No 3 Probably 4 Unknown σ. The law requires Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Be Division of Vital Other₄ examiner? Hospital: DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this Inpatient 2 1 V Yes No After t 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Driver auto fixed object collision Certification: FOUND: Natural Yes 2 ✔ No Pending Director: Mar 4, 2009 0330 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 900 Block of Maynew Inn Road, Oakland , MD (Specify) Local Street determined To the Funeral Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 5, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760, P.O. Division of Vital Records,

^{Day} 2009 Month MAR **Physician** 5 6:55 P DIEU THI SANFORD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL MONTGOMERY CENTER BETHESDA 8. Date of Birth (Month, Day, Year) June 15,1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 👿 F 79 Vietnam Director 535-74-6159 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Prince William Woodbridge Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or : 22193 United States 4308 Walsh Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Asian 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viet Thi Nguyen Ngoc Le 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) Nancy Katherine Keenan, Daughter 3610 Stokeley Street, Philadelphia, PA 19129 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20a. Method of Disposition
1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State West Laurel Hill Crematory 03/10/2009 Bala Cynwyd, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Choi Funeral Home, Inc. T.Harman Funera 247 N. 12th Street, Philadelphia, PA 19107 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) urs after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 2 No 1 ☐ Yes 2 😾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D67974 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 PARIZAD TORABI-PARIZI MD 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

200 MEMORIAL AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

KHOO

FRANCIS 31. Date filed (Month, Day, Year) 3-6-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 07083 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 200^{Ygai} **Physician** Norman Paul Sparks 9:10 a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (II not institution, give street and number) Examiner Parkville Baltimore Oak Crest Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 9, 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 216-20-4740 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Modeal Event, and out other traumatic event, the Modeal Event, and out other traumatic. Parkville 1 Yes 2 No Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8820 Walther Blvd. Apt. 1503 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Anna Bunn Raymond J. Sparks, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8820 Walther Blvd. Apt. 1503 Parkville, MD. 21234 Marguerita Sparks - wife permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory March 7,2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee And Wells 11605 Reisterstown Rd. Owings Mills, MD. 21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Endotase **Physician** heart failur disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Devere pulmonary hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and elely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown dependent COPP moderate gartic stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 3 CKronic kidney discuss performed' 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 061785 US

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

CHARN

-4740

8800 Walther Blud Parkville, MD 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Dixon

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien [] [] 9 07084 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** David Eustace Scott March 5, 12:20 P M 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Riverview Care Center Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Months Days Hours 1XM 2□ F 225-05-7155 Yrs 90 09/07/1918 Director Virginia Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County rel', or items 23e or 28e-f show Examiner must be notified at 1 ☐ Yes 2 🔀 🛠 0 Maryland Baltimore Middle River Direct 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 3 Pantly Court 21220 U.S.A. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2√2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If item 27 is marked other the eny injury or other traumatic event, ITEM 20028. 12 Timekeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Joshua Scott unk . Whitten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David R. Scott, Sr. (Son) 1207 St. Francis Road, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 12 Surial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 03/09/2009 Haltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Some ure of Fun Jal Service Licenses 23a. Part 1. Smorthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** orter disease or condition resulting in death) erman /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed Adra 11 attending physician and that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760. Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 🗆 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dements 1 Tes 2 No 3 Probably 4 Munknown e mery Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has , page 2 autopsy 2 No 1 Yes Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: Certification; To 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 TYes death. 2 Accident investigation the Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide ö within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature M.D 0005517 031 07/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3023 Sebastian JDL -Costera 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MARO 92009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** SMITH MARCH 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDOUSTOUR HOS PITAL BAUTIMORE NORTHWEST 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 65. 31. PG Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗹 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Exerciner must be notified at Battimore 1 Yes 2 No Funeral Director 10g. Citizen of What Country? et and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 may injury or other traumatic event, the Middell Exercises on 2 ance. a 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. ò Specify: Back 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Unemployment St. of 12 Elementary/Secondary (0-12) Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code)
2122 North and Rd., Ratt., MD 21207 19a. Informant's Name/Relationship (J pe. Print) onostrect (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shurelal Seves. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CAMIOVASCULAR ATHEROSCUERTIN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the aftending physician Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No Year 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 ☑No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorer stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number MARUM (C) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OURT ROAD 5401 2(13) ROTHICIN MICHAEL OND 31. Date filed (Month, Day, Year) 2. Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1 Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year Physician :25 AM 2009 MARC /Medical City, Town, or Location of Death a Facility Name (If not institution, give stre County of Death Examiner Park ltimore Keha atonsville (State or Foreign 8. Date of Birth (Month, Day, 9. Birthplace Country) (In yrs. **Funeral** 214-18-1692 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Example of motified at MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number USA Funeral . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: þ Specify: USA 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use noticed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Union f Health and Mental Hygier item 27 Is marked other the other traumatic event, the Father's Name (First, Middle, Last) Be (ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto., IN wow.
20c. Location - City or Town, State Grantly permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone. 20b. Place of Disposition (Name of cometery, crematory of other p Method of Disposition 1 Burial 2 Cremation 3 Removal from State .10.09 4 Donation 5 ☐ Other (Specify) of Feelity Greene Funeral Services 21. Signature of Funeral Service Licenses Natil Pilce Balto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YPOGLYCEMIA Immediate Cause (Final disease or condition resulting in death) **Physician** ONE DAY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an s certificate has blirector, page 2 s autopsy performed? 1 □ Yes Division of Vital Hospital or Attending Physiclan: 724 hours after death Funeral Director After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie On the Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, MARO 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 28, 2009 **Physician** 2:20pM ANTHONY JOSEPH SANSONI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1306 S. BAYLIS STREET BALTIMORE N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | PEC. 29, 1926 | PENNSYLVANIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 220-20-0047 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or iteme 23s or 28s-f ehow other traumatic event, the Mudical Examinar must be notified at 1 XYes 2 ☐ No Director MD " M/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BAYLIS STREET 1306 S. 21224 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Tyes 2 No
If Yes, Give
Year or Dates: 9 45 - 49 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Coltege (1-4or 5+) 12 CAB DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANTHONY SANSONI CATHERINE 2 BALONIS 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 S. BAYLIS STREET, BALTIMORE, MD. 21224 MICHAEL SANSONI/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: if ite
eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. STANISLAUS CEM. 3/5/2009 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee Z Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE year Physician /Medical Examiner HEART DISEASE PERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last attending physician and for use es the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. It yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown pege 2 should DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2 10 1 Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how intury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No efter deetn | Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours er To the Funeral D completely filled i 1x Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMONE MD 21229 ST AGNES COLE EW 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ,^{Day}2009 **Physician** MARCH JOSEPH C. SHENTON, JR. 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOSEPH RICHEY HOUSE BALTIMORE 8. Date of Birth (Month, Day, Year) JULY 24,1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days Months 1 X M 2 □ F Yrs. 65 219-40-4515 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 155 GRUNDY STREET APT. 230 21224 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ★★★ Es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Specify Specify: WHITE 3 Widowed 4XX vivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICIAN RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHENTON, SR. GERTRUDE **GETZ** ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA LAMBERT/ SISTER NORTH HAWTHORNE ROAD, BALTIMORE, MD. 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 3/6/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respirator Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 th No 1 ☐ Ye 1 Inpatient 2 ER/Outpatient 3 DOA 6 Dother (Specify)

Examiner burial-trar attending physi for use as the b as signed by the Records, certificate After this funeral death.

Funeral

Director

28a-f show

ed other than "natural", or items 23a or 28a-f show event, I'm soulcal Even internation of

"natural", or

Is marked other

27

Important: If it any injury or o

Physician

/Medical

altimore, Maryland 21215-0036

Exami Physician/Medical Completed Be ဥ Certification: filled in by the Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5 ☐ Pending

investigation

6 Coyld not be

State Registrar DHMH 17 Rev 1/2001

To the Hospital or Attend within 24 hours after death To the Funeral Director:

SEPH

ORIGINAL

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28a. Date of Injury

(Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:15 A FEB 28, 2009 BERTHA ELIZABETH TAYLOR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOSEPH RITCHIE HOSPICE BALTIMORE 8. Date of Birth (Month, Day, Ye OCT. 13, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 XF NC 98 1910 Director <u>217-30-2814</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Evanciner must be notified at 1 XYes 2 □ No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21205 3115 MCELDERRY ST Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK altimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 If Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME 12TH HOMEMAKER Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic eventage. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUISE ပ္ WILLIE OUALLS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3115 MCELDERRY ST., BALTIMORE, MD 21205 LENORA FEASTER/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1101 SULPHER SPRING 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 03/06/2009 ARBUTUS, MD 21227 ARBUTUS 21. Signature of Juneral Service License 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YEARS 20 disease or condition resulting in death) /Medical Due to (or as a con equence ou: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseque ice off Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown with occant higher osmelar coma certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 📉 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier alhanne s 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. EuTaw Sr. Ballo MD. 21210 31. Date filed (Month, Day, Year) State MAR 0 9 2009 Registrar

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Lecting Traylog

			1 _ State	laryland / Depa Cer	artment of He r <i>tificate of D</i>			ene 1. No. 2009	07090
			Registrar 1. Decedent's Name (First, Middle, Last)		imodic or D		2. Date of Death		3. Time of Death
П	Physici /Medic		Bertha B. Vondrac	ek			March 5	Day Year 2009	3:07 P ^M
- Are	Examir		4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or L			4c. County of Deal	
de de la constitución de la cons			The Woodlands	lane (In time Instituted at 1)		le River	8. Date of Birth	Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday) 90 Yrs.	Months Days	Hours Min.	(Month, Day, Y		thplace (State or Foreign ountry) Cyland
	ס		Usual Residence of Decedent				My 13,	i y i o i i mai	yrand
	ırylan show	<u></u>	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ba-f	ecto	Maryland Baltimore	Middle				011 (14) (0	1 ☐ Yes 2☐ No
	with t	ğ	10e. Street and Number 1520 Windlass Drive , Apt	359	10f. Zip Code 2122	0	109	j. Citizen of What Co USA	untry?
	ms 23	Funeral Director	11 Marital Status 12. Was Deceder		Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No-	14. Race - Ame	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	/Fu	Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No	lf Yes, specify Cuban, 1 □ Yes 2 7 □ No	, Mexican, Puerto F Specify:	lican, etc.)	Black, White Specify: Wh	
5-0036	ural",	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates				Lao		
75	in 72 in 72 in 'nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done dui DO NOT use retired)	ring most of workin	g 16	b. Kind of Business/	industry
2121	filed within Hygiene. Sther than "ent, the Me	mo	Elementary/Secondary (0-12) College (1-4o	r 5+)	ossing Gua	rd		Scho	ol _
	al Hy d othe	Be	17. Father's Name (First, Middle, Last)		1	8. Mother's Name		_^	
yla	should be fand Mental Sanarked oi	ဥ	Michael Zeberlein			Magda		Gensler	
Maryland	12 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street an				Zip Code)
	Heall tem 2	1	Beth Porter (daughter) 20a. Method of Disposition		John Avenue sition (Name of matory or other place)			c. Location - City or	Town, State
MO	Pages ient of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	e Oak Lawn		03/09	/2009 _{Ba}	altimore,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Sometimeral Source Liebaee		2. Name and Address	of Facility Bru			
<u>B</u>	8 3 E 8		The ford of the		1407 Old E				nd 21221
		1	23a. Part 1. Enter the disease, or a location that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dying,			t,	Approximate Interval Between Onset and Death
- may	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a.	Coronery	trien	1 513	ease	,	4460-5
4	Examiner		Due to (or a	as a consequence of :	C	1			
1	no sti	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or a	is a consequence of):					
	ecuted nd transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events c						
60,	be exectan a	Ě	resulting in death) Last Due to (or a	is a consequence of):					
68760,	ificate be executed g physician and is the burial-transit	edical	d						
Box (n/Me	IF FEMALE: 23c. If yes, outcom		7			23d. Date of de	livery
	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Live birt 1 ☐ Yes 2 ☑ No 4 ☐ Pregnan	at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
P.0	res that the de signed by the a be detached to	Phys	9 Li Unknown						
JS,	ires th signer	þ	Part II. Other significant conditions contributing to death Dia Selection Mo	(nderlying cause given	in Part (.		-	the cause of death?
of Vital Records,	w require s been sig should b	Completed	V143640 1116	Curren					·
Re	he law e has ige 2 s	dmo					24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
ta	siclan: The certificate h rector, page	Be Co	25. Was case referred to medical			26. Place of Death	1 □Yes 2, (Check only one)	∄No 1 □ Yes	2 🗆 No
Į V	di isi	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatier	Othory			ce 6 dother (Spe	city his iteline
		L:uo	27. Manner of Death 1 Natural 5 Pending (Month, L	njury 28b. Time of Injury	Work?	at 2	8d. Describe how		
sio	att at	cati	2 Accident investigation			es 2 No	Dr. Landing and	_	
Division	l or Attene after death Director:	Certification:	determined 200. Flace UI	njury - At home, farm, stretc. (Specify)	eet, factory, office	2	City or Town, S	et and Number or Ru State)	irai Houte Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying Physician: To the beautiful Certifier 1 Certifying Physician: To the beautiful Certifier 1 Certifi	st of my knowledge, death	h occurred at the time	e, date and place, a	nd due to the cau	ise(s) and manner a	s stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examiner: On the basis and manner	of examination and/or in stated.	vestigation, in my opi	nion, death occurre	d at the time, date	e and place, and due	to the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	? 0	29c. License r	number	29d	Date signed (Mont	h, Day, Year)
	6		H		()	0339	•	3/6/2	009
	UV			death (Item 23a) (Type,	, MD 212	21	br. Fo	sha Lo	4
¢.	Sta			strar's Signature	es)				
	Registr	ar	MAN & GUUD CHAM	p. gar					

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland / Dep	partment of Health and lertificate of Death		ne No. 2009	07091
			Decedent's Name (First, Middle, Last			2. Date of Death		3. Time of Death
	Physicia /Medic		Sharon Wych	e			Day Year	1025° M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	n A
el .			5. Social Security Number 6. Se		Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9/Birth	pplace (State or Foreign
	Funeral Director			M 2 M F 7. Age (11. yrs. 12.50 b) 11. Age (11. yrs. 12.	Months Days Hours Min.	Feb 24	751 Dist	intry) tof Columbia
	p .		Usual Residence of Decedent			1100.001	101011	
	arylar show	,	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits 1 No 1 No
	the M 28a-f lotifie	Director	10e. Street and Number	t Bal	10f. Zip Code	100	Citizen of What Cou	
	with with the rate of	II Dii	5901 Clank	ick Dd	21239	log.	110	A
	death ms 2; r mus	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer	
စ္	after or ite mine		1 ☐ Never Married 2 Married	1 □Yes 2V7No	1 Tes 2 No Specify:	o Rican, etc.)	Black, White	, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		140		Jack
212	n 72 l i "nat edici	Completed	15. Decedent's Edu (Specify only highest grad	le completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	. Kind of Business/li	ndustry
212	yiene. r thar	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	inistrative A.	ssistant /	Iniv. Of	- Md.
9	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)	0.1	18. Mother's Nan	ne (First, Middle, Maio	len Surname)	
<u> </u>	should be filed within 72 hours after death with the Marylar and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Evaniner must be notified at	2	James (J. Pilson	Itran	nces	Koss	
Maryland	12 sho h and r is ma rrauma		19a. Informant's Name/Relationship (7)	rpe. Print) husband 19b. Mai	ling Address (Street and Number or Ru	iral Route Number, Cit	y or Town, State, Z	ip Code)
	s 1 and 2 should of Health and Mei item 27 is marke other traumatic		20a. Method of Disposition	20b. Place of Disp	Dosition (Name of	Date 20c.	Location - City or T	own. State
ē	ö O		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ematory or other place)	I	Balto	MI
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Licens	1010011110	22. Name and Address of Facility	unk L	201101	1.16
ñ	Per Brand		Arroph 2	Kurs 2	222 W. North Av	e. Baito.	Md. 213	16
			23a. Pary 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not en ne cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pheumonia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				e
		er	Sequentially list conditions, all cause. Enter Underlying Cause (Disease or injury	b. Multiple Myelo Due to (or as a consequence of):	ma			3 4°s
	cuted nd ransit	Examiner	that initiated events	с				
Ď,	oe exe cian a urial-t		resulting in death) Last	Due to (or as a consequence of):				
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d				
Š X	certifi nding ise as	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of deli	werv
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
л. О	t the by the tacher	Physician/Med	9 Unknown	9 Unknown				
	w requires that the d been signed by the should be detached	þ		ntributing to death but not resulting in the				the cause of death?
Vital Records,	requir	Completed	Thumborytopeni	a due to bone man	row suppression	1 L Yes	2 rNo 3 Pro	bably 4 🗌 Unknown
ec T	e law has b	mple				24a. Was an autopsy performed	prior to c	topsy findings available ompletion of cause of
ā	ding Physician: The lav h. After this certificate has funeral director, page 2		25. Was case referred to medical			1 □ Yes 2 🔀	No 1 ☐ Yes	2 □ No
5	ysicia s cert directo	To Be	examiner?	Hospital: 1 ∭inpatient 2 ☐ ER/Outpation	Othor	ath <i>(Check only one)</i> Iome 5 □ Residence	6 ∏Other (Snec	rify)
0	ng Ph fter th	L:u	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in		
S S	• Attendir er death. rector: A by the fu	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐Yes 2 ☐No			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the Funeral director, to the funeral director, to mpletely filled in by the funeral director, to	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	S a		sician: To the best of my knowledge, dea				
	he Ho in 24 } he Fu pletely	ledical	(Check only 2 Medical Exam	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	Vith Tot COE	Σ	29b. Signature and title of tertifier		29c. License number		Date signed (Month	, Day, Year)
		ļ	1 KADOU	るさ	P23051		3-6-09	
_			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type 1KORI – NELSON 2	Print)	Baltima	o MN.	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	No.		1000	- (60)
	Registr	ar	MAKU 9 ZUU9	thereton by it				

>		Р	lease 1	Type or Pr			delible Ink artment of I			-		_	le.	
		For State Registrar			nai yiai ic		rtificate of				Reg. N	201	39	07093
Physici /Medic Examin	al	1. Decedent's Name (First, I		J.	(r)	10,11	4b. City, Town, o	or Location	of Death	2. Date of D Month 03	6	ay 5 2 c. County o	Year 109 f Death	3. Time of Death
Funeral Director		5. Social Security Number 214-50-390	6. Se	X M 2□F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of B	irth Day G a	49	9. Birthpla Countr	ce (State or Foreign y) MD
Maryland a-f show	ctor	Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Lo	nore				_		100	d. Inside City Limits 1 Yes 2 No
with the 3a or 28	Funeral Director	3724 W.	Fair	mount	- Ave	nue	10f. Zip Code	223			10g. C	Citizen of Wh		y?
be filed within 72 hours after death with the Maryland trail Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Eventian must be natified at	þ	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo		12. Was Deceder Armed Forces 1 X Yes 2 [If Yes, Give Year or Dates	s?] No		Nas Decedent of I f Yes, specify Cub	Hispanic Or pan, Mexican Specify.		ecify Yes or N Rican, etc.)	lo-	14. Race	- America White, etc	
2 2 g	Completed	15. Dec (Specify only I Elementary/Secondary (0-		ication le completed) College (1-4o	r 5+)	(Give	dent's Usual Occu kind of York done DO NOT use retire	during mos ed)	st of worki	ng	16b.	Kind of Bus	ness/Indu	stry C
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, Ina Medie once.	To Be (17. Frather's Name (First, Mi	W:	11:am	s, Si w:fe)	19h Mailir	ng Address (Stree	Je	an		To	inst	al	Coda)
t and 2 s Health an Health ar Health ar Hem 27 is of		Gwendolyr 20a. Method of Disposition	L. V	N:11:ams		272	4 W. Fa	urm	ount	Ave .	Bo	Location - C	ME	, 21223
nit. Pages artment of ortant: If its injury or o		1 Burial 2 Crema 4 Donation 5 Oth 21. Signature of Fun ra Se	er (Specify)	·	e Cce	metery, crer	natory or other pla		3.1	2.09	Du	ungs	<u>M:11</u>	s, MD
Department of the permitted of the permi	v 10	Vaughn	_ (¹	. Kreen	e	5	151 Bal	to. N	lat	P.16	une	212	29)	
Physician Medical Examiner		23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complication List only of	ne cause on each a. Sep	ed the death. line.		er the mode of dyl	ing, such as	cardiac (or respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate the cause (Disease or injury	Į	b. Due to (or a	s a conseque	ence of):							-	
eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last		Due to (or a	is a conseque	ence of):								
The law requires that the death certificate be atte has been signed by the attending physicial bage 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 2	23c. If yes, outcon 1 Live birth 4 Pregnan 9 Unknowr	2 Fetal of at time of de	death 3] Ectopic pregnand] Other <i>(specify)</i> _	су				23d. Date Mont		/ vay Year
equires that en signed to	Ş	Part II. Other significant co	nditions co	ntributing to death	but not result	ting in the u	nderlying cause gi	ven in Part I						cause of death?
	Completed									24a. Wa auto per 1 □ Yes	opsy formed?	pri de	ere autops ior to comp ath? Yes 2	ey findings available bletion of cause of
ding Physician: After this certific funeral director,	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	-	Hospital: 1 1 Inpa	itient 2 E	R/Outpatier	t 3 DOA Oth	hor:		n <i>(Check only</i> me 5 ☐ Rea		6 □Other	(Specify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	ertification:	3 ☐ Suicide 6 ☐ C	ending vestigation ould not be etermined	28e, Place of I	Day, Year)	28b. Time of Injury ne, farm, str	Wo	iry at rk? ∃Yes 2 □	No	28d. Describe 28f. Location City or To	(Street a	and Number		Route Number,
Hospital of the Post of the Po	Medical Ce	29a. Certifier 1 Cer (Check only one)	tifying Phy lical Exami	sician: To the besiner: On the basis and manner	of examination	/ledge, deat	n occurred at the t vestigation, in my	ime, date a opinion, dea	nd place, ath occurr	and due to th	e cause	(s) and man	ner as sta	ted. he cause(s)
To the within: То the comple	Mec	29b. Signature and title of ce	rtifier		MD		29c. Licen:	se number	04		29d. D	ate signed	(Manth, Da	ay, Year)
7		30. Name and address of pe	rson who co	S	22	SG	reen St	Bal	time	01C,1	MD		1201	
Sta Registr		31. Date filed (Month, Day, MARO 9		32. Regis	strar's Sgnatu	park)							

DHMH 17 Rev 1/2001

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01666 nald Warren		Please Type o	of Maryland / Depart	tment of	Health	and Menta	al Hygiene)	21	009 070	9
		or State	Certi	ficate of	Death			Reg. l		3. Time of Death	7··
Physician		g istrar Decedent's Name (First, Middle,Las	t)				2. Date of Month	D:	ay Year	0936 hrs	
امتار	er	DONALD WARREN, S	R		1h City Toy	vn, or Location of		ary 26,	4c. County of D	eath	-
	48	. Facility Name (if not institution, giv Washington County Hosp		1	Hagers		D000.		Washingto	n	
	_	Social Security Number LINK 6. Se		st birthday)	If Under		24Hrs. 8. Date	of Birth(I	MM/DD/YYYY) S	, Birthplace (State or	1
Funeral Director				Yrs	Months	Days Hours	Min.	2 2	1950	oreign Country) MD	
Director		sual Residence of Decedent	M 2 F 58		1		I]
any	_	Da. State 10b. County	10c. City, 1	own or Locat	ion					10d. Inside City Limits 1 X Yes 2 No	
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after death with the Maryland ral", or items 23a or 28a-f show iner must be notified at once.	Funeral Director	De. Street and Number			10f. Zip C	ode		10g.	. Citizen of What	Country?	
the M	盲	18601 ROXBURY RI) .		217	740	10 10 11 15 V-		JSA	American Indian, Black,	4.
with the ms 23a be noti	era 1	Marital Status	12. Was Decedent Ever in U.S	5. 13. Wa	as Decedent Yes, specify	of Hispanic Origi Cuban, Mexican,	n? (Specify fe Puerto Rican, e	tc.)	White,		1
death or ite	֟֝֟֝֟֟֝֟֝֟֟֝֟֝֟֟֝֟֟֟֝	Never Married 2 Marrie	1 Yes 2 X No		Ves 25	No specify:			Specify:	BLACK	
s after ral", niner	<u>ا</u> ھ	Widowed 4 X Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates:	16a Decede	nt's Usual O	ccupation (Give k	ind of work don	e 1	16b. Kind of Busin	ness/Industry	1
hour "natu	ted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of worki	ing life. DO NOT	use retired)				
36 hin 72 e. than	Completed	12TH		C00	K				TAVER	N	4
5-0036 iled within 7 Hygiene. d other than the Medica	5 1	7. Father's Name (First, Middle, Las	t)			1			aiden Sumame)		
AD 21215-0036 2 should be filed within 72 hours h and Mental Hygiene. 27 is marked other than "natur	a B	SAMMY MULLINS	Pint)	10h Mailir	ag Address	(Street and Num	ETHA WA	RREIN ute Numb	er, City or Town,	State, Zip Code)	7
21 should is man	<u>1</u>	9a. Informant's Name/Relationship				GILMOR S				21217	1
- B # E # E	-	CLEADER WARREN/20a. Method of Disposition	20b. F	Place of Dispo	sition (Nam	e of cemetery,	Date		20c. Location - 0	city or Town, State	
altimore, mit.: Pages I ar apartment of He prortant: If ite		1 Burial 2 X Cremation 3	Removal from State	crematory or o			03/02/2	009	HANOVE	R. MD	
ti. Pag	Ļ	4 Donation 5 Other Special Signature of Funeral Service Lice	fy:	ARU 22.	ENT Name and	Address of Facility	WESLEY	CHA	VIS, JR.	FNRL. HM.	
Bal permi Depar Impo		Assela. D	K . (1)	i	2007	OO EXCUE	TON AVE	. BAI	TITMORE.	MD 21231	
Physician	1	23a. Part I. Enter the Ju ease, or cor failure. List only one cause on	nolications tha sed the death	. Do not enter	the mode o	f dying, such as o	ardiac or respira	atory arre	st, shock, or hear	Between Onset and	
Madical			a. Atherosc <u>lero</u>	tic ca	rdiva	scular d	isease			Death	4
		or condition resulting in death)	Due to (or as a consequence of	of):							1
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of	of):							
		cause. Enter Underlying Cause (Disease or injury that initiated	c								\dashv
d sit	xar	events resulting in death) Last	Due to (or as a consequence of	of):							
executed ian and ial - transit		XUNPENDED	XAMENDED 23a PII	, <u>2</u> 7,pg	rME	g890 4/8	3/09 TT				
760, icate be e	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pres	nancy	394 87	13/09 11			23d. Date of		
876 tificat ng ph as the	N/L	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death		ic pregnancy		Month	Day Year	п
cox 687 eath certific attending p	Sicis	1 Yes 2 No 9 Unkno	Pregnant at time of d Unknown	eath 5	Other (Spe	cify)			T		1
). BC the der by the a	ig Si	Part II. Other significant condition	3 Olikilowii	resulting in th	e underlying	cause given in F	Part I. 2	3e. Did to		bute to the cause of death?	
P.O.	≦		al disease on d				1	1 Yes		Probably 4 V Unknown	_
ds, Fequires	Completed						2	4a. Was autop		Vere autopsy findings availab rior to completion of cause of	le f
COF law r has b	힐							v yes		leath? ✓ Yes 2 No	
tal Rection: The certificate ector, page	Ŝ	25. Was case referred to medical				26.Place of Deat	h (Check only o	ne)			
Vital Records, system: The law requir this certificate has been state of the law required that the state of t	a	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpati	ent 3 [OOA Other	Nursing Hor		Residence 6	Other:	
n of V ling Phy After th funeral	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time	of Injury	28c. Injury at Wo	_	Describe	how injury occuri	red	
on on ath.	tion	1 X Natural 5 Pendir	g			1 Yes 2			Ol and and Mark	or as Dural Poute Number C	itv
ViSion Attendent de	ifica	2 Accident Investi 3 Suicide 6 Could	28e. Place of Injury - At	home, farm, s	street, factor	y, office building,	etc. 28f.	Location(or Town,\$	Street and Numb State)	er or Rural Route Number, C	ty
Divisior pital or Attend ours after death neral Director: filled in by the	Certification:	4 Homicide determ	(-1 7/					- 10	oo(a) and manne	r as stated	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.		Control city	sician: To the best of my knowle iner:On the basis of examination	edge, death of and/or invest	ccurred at th tigation, in m	e time, date and ny opinion, death	prace, and due t occurred at the	time, date	and place, and	due to the cause(s)	
Fo the Hos within 24 h To the Fun	Medical		and manner stated.			c. License numb				ned (Month, Day, Year)	_
	Σ	29b. Signature and title of certifier	MID			O.C.M.E.			February 2	27, 2009	
		, my	the completed cause of death (Its	em 23a)							
LONA		30. Name and address of person v Ling Li, MD Assistan	t Medical Examiner 11	I1 Penn St	treet, Balt	timore, MD 2	1201		_		
PS	_	of Data Stad (Atauth Day Year)	32. Registrar's Sign		bark						
	State										

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ren watson			ertificate of Death	Reg. No. 2009 0709
Physici edical Exam		1. Decedent's Name (First, Middle,Last)	Watson	2. Date of Death Month Day March 1, 2009 3. Time of Death 1821 hrs
		4a. Facility Name (if not institution, give street and number) 3004 St. Lukes Lane	4b. City, Town, or Location of Death Woodlawn	
Funeral Director		114-44-2807 1 M 2/F	last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	- 1 _E
d how any ee.	L	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Location	10d. Inside City Limits 1 Yes 2 No
5-0036 Hed within 72 hours after death with the Maryland lygiene other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	10e. Street and Number 3004 St. Lukes Lan	10f. Zip Code 21207	10g. Citizen of What Country?
r death with th or items 23a must be noti	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	U.S. 13. Was Decedent of Hispanic Origin? (S	Rican, etc.) White, etc.
hours after 'natural'', (Examiner	by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	Specify: Black work done red) 16b. Kind of Business/Industry
15-0036 Ided within 72 hours after Hygiene. Id other than "natural", the Medical Examine.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last)	Teacher 18. Mother's Name	Education (First, Middle, Maiden Surname)
121 Id be fil fental F narked event,	To Be C	Philip Randolph 19a. Informant's 'ame/Relationship (Type, Print)	Iono	
MD and 2 sho alth and 27 is			D. Place of Disposition (Name of cemetery, crematory or other place)	C+, Apt. 3A Ballinge, 7844 Date 20c. Location - City or Town, State
LimC Page Iment tant:		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21, Signature of Funeral Service Licensee		-10-09 Bartimore, MD
Ball Ball Depart Import		23a. Part I. Enter the disease, or complications that caused the dea	th. Do not enter the mode of dying, such as cardiac of	L Randalktown w 21133 or respiratory arrest, shock, or heart Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The pertensive of the condition resulting in death) The pertensive of the condition resulting in death)	atherosclerotic cardio	Vascular disease Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	e of):	N To the second
ecuted and - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence		
60, ate be exe thysician a	Medical	X UNPENDED AMENDED 23a, PI IF FEMALE: 23c. If yes, outcome of pre	I,27,perME, g889 3/11/09	23d. Date of delivery
Ox 687 eath certific attending p	sician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 1 Unknown	2 Fetal death 3 Ectopic pregna	
P.O. Es that the igned by the detached	d by Phys	Part II. Other significant conditions contributing to death but not Cocaine use	t resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
O = € 1	Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 Vere autopsy findings available prior to completion of cause of death?
tal Rec rinn: The certificate ector, page	Be C	25. Was case referred to medical examiner? Hospital: 4 Increase 2	26.Place of Death (Check	only one)
of Ving Physical After this uneral dir		1 ✓ Yes 2 No Prospital 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Other Nursi	ng Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred
Division of Vital ral of vital ral of vital ral of Attending Physicians: rs after death. After this certifuled in by the funeral director.	Certification: To	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	28f. Location (Street and Number or Rural Route Number, City
Divi		4 Homicide determined (Specify)		or Town, State)
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
F % F 8	Me	29b. Signature and title of certifier (a) a A A A A A A A A A A A A A A A A A A	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 2, 2009
		30. Name and address of person who completed cause of death (Ite Carol Allan, MD Assistant Medical Examiner	em 23a) 111 Penn Street, Baltimore, MD 2120	11
	tate	31. Date filed (Month, Day, Year) 2. Registrar's Signa	ature	
Regis	urar	MAR 0 9 2009 Server A	park	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 17. 2009 6:15 \mathbf{A}^{M} Neil Ross Atwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1.☐M 2☐F Months \$ept.17, Director Maryland 76 1933 215-30-5450 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b County show th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1∏Yes 2□No Director Anne Arundel Maryland Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21403 United States 20 Boxwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 □ No If Yes, Give Korea Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2**X**□XNo Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter U.S. Naval Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event any injury or other traumatic event ance. Be Emma Virgina Hurley William Wesley Atwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Boxwood Road Annapolis, Maryland 21403 Norma M. Atwell / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Crownsville Vet. Cem. 3/2/2009 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence in: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami certificate be executed Vascu burial-trans and Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 □Yes al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D53111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Honapolis Medical 31. Date filed Month, Day, Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Cynthia Rae 19, 2009 Ambush 9:30 P February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5529 Wicomico Drive New Market Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 162-46-4927 Jan 3. 1952 Pennsylvania Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Director 1 ☐ Yes 2 🛛 No MD Frederick New Market 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5529 Wicomico Drive 21774 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: or) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. "Important: If item 27 is marked other than "rang any Injury or other traumatic event, the IP 30 Quee. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Ray Brandt Maybelle Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda S. Oney/daughter 5529 Wicomico Drive New Market, MD 21774 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 02/21/09 Odenton, MD 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the crease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Hyperkalemia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** b. Acute Renal Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed c. Recurrent Lung Cancer
Due to (or as a consequence of): burial-trar Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Metastases to Peritoneum 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 XNo or Attending Physician: The 1 ☐Yes 2 ☐ No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1∐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26110 D146 26 February 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. G. Rausch, M.D. 501 W. 7th Street Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 Registrar

attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Physician

/Medical

Examiner

Director

Funeral

<u>۾</u>

Completed

Be

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be retified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, in Media once.

Physician /Medical

Examiner

3altimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant at time of 9 ☐ Unknown	death 5 ☐ Other (sp	ecify)			
Part II. Other significant condition	ons contributing to death but not re-	sulting in the underlying ca	ause given in l	Part I.		e contribute to the cause of death? No 3 Probably 4 Unknown
					24a. Was an autopsy performed? 1 ☐ Yes 2 € No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referred to medica			26.	Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatient 3 □ DC	Other: 4	☐ Nursing Hom	ne 5 Residence 6	Other (Specify)
27. Manner of Death 1. Natural 5 Pendir 2 Accident investi	gation	28b. Time of Injury M	8c. Injury at Work? 1 □ Yes		8d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		nome, farm, street, factory ify)	, office	2	8f. Location (Street and City or Town, State)	l Number or Rural Route Number,
	ng Physician: To the best of my kn Examiner: On the basis of examin and manner stated.					

009178

29d. Date signed (Month, Day, Year)

23

Hollywood, MD 20636

00

State Registrar

31. Date filed (Month, Day, Year)

Youngsik Moon, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



24435 Mervell Dean Road

			For State	State of Marylan		artment of F rtificate of			200.	07099
		ey.	State Registrar		Ce	illicate of	Dealli	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		1. Decedent's Name (First, Middle, Last)					Month	Day Year	
	/Medic	al	Beatrice 4a. Facility Name (If not institution, give	Allen		4h City Town o	r Location of Death	Februa	4c. County of Dea	
	Examin	er	Charlotte Hall V				otte Hall		St. Ma	_
,	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		198-18-0346	M 25xF 92	Yrs.	Months Days	Hours Min.	Jan. 29	9, 1917 Per	ountry) nnsylvania
	p.		Usual Residence of Decedent	400 Cit	y, Town or Lo	action				10d. Inside City Limits
	arylar show d at	<u>-</u>	10a. State 10b. County	Toc. Cit	y, Town or Lo	ocation				1 Yes 2 TNo
	Ba-f	Director	Maryland St. Ma	ry's	Cha	10f. Zip Code	a11		10g. Citizen of What Co	
	hours after death with the Maryland Lural", or Items 23a or 28a-f show al Examiner must be notified at		10e. Street and Number	11 D 1			0600			•
	is 23	Funeral	29449 Charlotte 11. Marital Status	Hall Koad 12. Was Decedent Ever in U	.S. 13.		0622 Ilspanic Origin? (S	pecify Yes or No-	USA 14. Race - Ame	
_	ter d Iter iner	필	1 Never Married 2 Married	Armed Forces? 1 ★ Yes 2 No		Was Decedent of H If Yes, specify Cub		o Rićan, etc.)	Black, Whit	e, etc.
20	urs al	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify: Wi	nite
9500-61212	2 hor	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of Business	/Industry
7	thin 7 e. an "r Med	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	nurg		
	i filed within 72 h I Hygiene. other than "natuent, the Medica	Completed		3	Re	egistered		(5)	U.S. Gover	cnment
	9 6 - 5	Be	17. Father's Name (First, Middle, Last)	7 - 11			_		Maiden Surname)	
<u>\S</u>	should be find Mental I	은		Colbert	405 14-11	Add (Car	Bertha		Newell.	7:- 0-4-)
	is is		19a. Informant's Name/Relationship (Ty	oe. Print)		,			•r, City or Town, State, . • VA 22003	Zip Code)
	1 and Health em 27 em 27		David Allen/Son 20a, Method of Disposition	20b. I	Place of Dispo	osition (Name of		Date	20c. Location - City or	Town, State
و	Pages nent of I ant: If ite ary or o		1 ☐ Burial 2 🛣 Cremation 3 🗆 F	emoval from State		matory or other pla e1d-Echo1	· · · · · · · · · · · · · · · · · · ·	24/2009	Charlotte	
Baltimore,	artme artani artani injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	A	2	2 Name and Addre	ss of Facility	_		
g	permit. Page Department of Important: If any injury or once.		MA	M0081		Brinsfiel 30195 Thr	d-Echols	Funeral Rd. Ch	Home, P.A.	i1, MD 20622
			23a. Part1. Enter the disease, or compl	cations that caused the deal						Approximate Interval Between
	Physician		shock, or heart failure. List only of immediate Cause (Final		0.0	OUNTER	0.00			Onset and Death
ķ	/Medical		disease or condition resulting in death)	Due to (or as a consec		KHIIII	N_LH			
	Examiner			PULMONA	RY	HYPERT	ENSTO	4		
	200	ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consec		***************************************			7-1	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	CHRONIC	OBST	RUCTIV	E PULM	ONARY	DISEASE	
Ď,	e exe an ar ırial-t		resulting in death) Last	Due to (or as a consec	uence of):					
8760,	icate be executed physician and s the burial-transit	dical		l						
9	ertific ling p e as t	Mec	IF FEMALE:	0- 16						
. Box	leath certifi attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregn 1☐Live birth 2☐Feta	aldeath 3[Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
o O	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5	Other (specify)				
<u> </u>	The law requires that the death certifi tte has been signed by the attending I age 2 should be detached for use as	P.	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Vital Records,	signe d be	d by						1 🗆 Y	′es 2 No 3 P	robably 4 nknown
Ö	w require been si should t	Completed						24a. Was a	an 24h Wero a	utopsy findings available
ĕ	The law	g L						autop perfo	prior to death?	completion of cause of
g			25. Was case referred to medical				Of Place of Dec		2 No 1 Yes	3 2 No
	Physician: r this certifica ral director, p) Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐	I FR/Outnatia	nt 3 DOA Oth	IOF:	ath (Check only o	ne) ience 6 ⊡Other (Spe	ngiful
Division or	<u>a</u> = <u>e</u>	2	27. Manner of Death	28a. Date of Injury	28b. Time o				now injury occurred	эспу)
o	th.: :: After	igi	Matural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		rk? Yes 2∐No			
VIS.	after death Director:	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number,
	tal or s afte al Dir ed in	Certification:		building, etc. (Spec)	.7/			Jany of 10h	, Julio)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			sician: To the best of my knoner: On the basis of examina						
	the H iin 24 the Fi	Medical	one)	and manner stated.						
	With To 1	Σ	29b. Signature and title of certifier	000		29c. Licens			29d. Date signed (Mon	
	8 /	1	Attillow,	MD		1.067	788		2:24	. 2009

State Registrar 31. Date filed (Month, Day, Year) FEB 2 5 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Charlotte Hall, Maryland 20622

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13:20 M Hnac Feb 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel BALTIMORE WASHINGTON MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĦF Days 219-12-3329 2, 84 Feb. 1925 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at tX Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 1407 Dale Drive 20910 items 23a USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**Io 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Parish Secretary Church 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) William Thomas Jones Marion Lee Perry ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alison P. Angel/Daughter P.O. Box 134, Vinalhaven, Maine 04863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 19 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W, Silver Spring, 21. Signatyre of Funeral Service Licenses Cleson M MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 7 days heumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit physician end s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0068123 pracec Name and address of person who completed cause of death (Item 23a) (Type, Print) Bune 301 Hospital Drive, Glen Burne, MD 21061 DANICA NOVACIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician G-43AM Fe b 28 100 2009 /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If Jot institution, give street and number) Examiner ocent GenHODR Howa DIQ Ce m If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🕽 F Massachusetts 031-03-0282 Director 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Columbia Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 7369 Swan Point Way U.S.A. 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Massachusetts Elementary/Secondary (0-12) College (1-4or 5+) Staff Assitant Labor Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Russo Joseph L. Vadala ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7369 Swan Point Way, Columbia, Maryland21045 Thomas J. Alizio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) St.MichaelCemetery 3/5/09 |Boston,Massachusett\$ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 6009Harford Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final e roare **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certification: To Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury s after dec. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E RINKU 0

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State Registrar

31. Date filed (Month, Pay,

strar's Signature

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			30. Name and	address of person w	ho completed car	use of death	(Item 23a) (Typ	oe, Print)	SENE	VIX ST.	FRE	DER	rek	M	0 21	701
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	Examin	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Cent	or		Location of Death		4c. County of D	eath Arundel
,6"	Europal			rs. last birthday)	Annapo If Under 1 Year	OLLS If Under 24 Hrs.	8. Date of Birth		-
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2	カサトゥ		Shirley Mae Perry(Niece)		Winfie				Md. 21054
HOF	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	tenetery, cren emoria	mesylme of natory or other place 1 Garder	ns 2-18		oc. Location - City Annapo1 :	
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	To the Hospital or Attending Physician: within 44 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to make the funeral director; to the funeral director director; to the funeral dire	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
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	NO DE		30. Name and address of person who completed cause of death (It	em 23a) (Type, I	Print)	el Me	dien	(onte	5 v .
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sig	A. Sa	Mad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Ž2, **Physician** February 2009 2:15 P Stephen Buda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours Min 1**∑** M 2□ F Yrs. 220-58-6119 55 1953 Washington, Jun 10. D.C Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 28a-f shov 1 ☐ Yes 2 No Director MD Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number USA Funeral 11620 Fort Washington Road 20744 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Emergency Medical Technician <u>Healthcare</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Christine Peterson Stanley Joseph Buda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Titherington-Buda/wife 22 Cottage Field Court Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W. Arundel Crematory 02/24/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ging home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 In Nursing Home 5 In Residence 6 Mother (Specify) hospice 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D64615 February 23, 2009 10 EG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D. 6001 Muncaster Mill Road Rockville, MD 20855 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** , 200 ORNE 1:08 PM abuar /Medical Facility Name (If not institution, give street and number) or Location of Death County of Death Examiner Nuv 19 crien 04g (10,000 06 91 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Days Hours Months 0872371919 89 MD Director 215-09-6371 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 □Yes 2 No Director MD Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21044 6443 Cedar Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Hygiene. the Homemaker own home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be and Mental If item 27 is marked or other traumatic ev Joseph Edward Taylor Mary Gertrude Pumphrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Alvin Bussey - son 1930 Brady Avenue Halethorpe, MD 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 28 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or Friendship Cemetery 02/25/09 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licenses n 0:044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0490511 /Medical Due to (or as a consequence of): Examiner 10491 Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the as attending asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 pronths? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 100 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate Vital 1∐ Yes Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 → No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 0 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 Natural Injury death. 1 🗌 Yes 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier <u>8</u>

To the I within 24 (6)20

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Person who completed cause of death (Hern 23a) (Type, Print)

(UWI

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and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 2:08AM 2009 imoth. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice 10. sex omic 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Year) Days 12 1930 22312 *2*22 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State "natural", or items 23a or 28a-f show 1 Yes 2 No Funeral Director MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SF 21811 12. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Marylahd 21/215-0036 Black Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than aborer onstruction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Un Known UNKNOW! 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellison Kauffman 19945 Lane x present 1 Daughter trank ford injury or other Department of Heam mportant: If Item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Lidensee 22. Name and Address of Facility Bennie Smith Funeral Home 3180 MD 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BROCHOGENIC Physician CARCINOMA WITH BONZ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2☐No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2/100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 Yes 2 AHO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical completely (Check only one) Medi and manner stated.

State Registrar 29b. Signature and title of certifier

6 Hautin WAM

FEB 20

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COAS TAL

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mothu

29c. License number

00058410

29d. Date signed (Month, Day, Year)

P.U BOX 1733 SHOWS BUY ap 21802

Funeral Director

Physici /Medic Examin

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Medical Evanciae rount to rottlind at angle.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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2	19a. Informant's Name/Relationship (Ty	ne Print)	Бе		g Address (Street a			al Boute Num	her Cit	, or Town	State 7		
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	4 Donation 5 Other (Specify) Springhill Memory Gds; 2-24-2009 Hebron, Maryland 21. Signature of Fundal Service Ligensee 22. Name and Address of Facility Bounds Funeral Home												
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	23a. Pa . Enter the disease, or comp.	ons that ca	used the death.							y , 110	IL y Lc	Approximat	te
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medical cel tillcation, to	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
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2	29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)						
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	30. Name and address of person who co	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANPET P. KUUG, 100 E. Concell struct, John Sury, M.D. 21801											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	ı	4a. Facility Name (if not institution, give street and number) 4b. City Southern Maryland Hospital	r, Town, or Location of		4c. County of Death Prince George's							
Funeral Director		578-24-3351 _{1 M 2x F} 92 _{Yrs.} Mor	nder 1 Year If Under hths Days Hours	24Hrs. 8. Date of Birtl Min: 10-5-1	h(MM/DD/YYYY) 9. Bird Foreig Co							
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Division of V To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	⊢⊦	1 W Yes 2 No 128 Date of Injury 28h Time of Injury 28h Injury at Work? 28h Describe how injury occurred										
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) assisted living facility 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the I within 2. To the E complete	Medical	one) 2 • Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	≥ -	(anloskend	O.C.M.E.		February 20, 200							
			et, Baltimore, MC	21201								
Sta Registr												
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OCME

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			For State Registrar	State of N	mai yiai i		rtificate d			aniai ny	Reg. No.	2009	07109
	Physic /Medi		1. Decedent's Name <i>(First,</i> Gabrie		-у					2. Date of De Month ebruar	Day	, 2009	3. Time of Death 6:18 p M
	Examir			titution, give street and numbe	r)		4b. City, Tow					County of Death	ory
	Funeral Director		5. Social Security Number 124-26-6613 Usual Residence of Decede	1 M 2 □ F	age (In yrs. la		If Under 1 Ye	thesda ear If Und eys Hour		B. Date of Bir (Month, Da Dec. 1	th ay, Year) 0 , 19	Montgom 9. Birthp Count Pola	place (State or Foreign
	aryland show		10a. State 10b. C		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	the Maryland r 28a-f show	recto	Maryland Mo	ntgomery	Gai	thersb	urg 10f. Zip Coo	10			10a Citiz	en of What Coun	Yes 2 No
acs.	ath with 23a or	Funeral Director	15649 Haddon	field Way			,	878			rog. Onz	U. S. A	,
E 5000	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madical Examinating the motified at	þ	11. Marital Status 1 Never Married 2 1 Div	If Yes Give	?] No		Vas Decedent fYes, specify (□Yes 2X			ify Yes or No can, etc.)		4. Race - Americ Black, White, 6 Specify: Whi	etc.
215-(ithin 72 hours ne. nan "natural",	To Be Completed	15. De (Specify only Elementary/Secondary (0	cedent's Education highest grade completed) -12) College (1-4or	5+)	16a. Deced (Give life. L	lent's Usual Oo kind of work do OO NOT use re	ccupation one during m tired)	nost of working	1	16b. Kin	d of Business/Ind	dustry
d 21	filed w Hygier tther th	Co	17. Father's Name (First, M	5+		Bio	Medica		earch other's Name (First Middle		I. H.	
lan	Aental Aental rked o tic eve	O Be	Mordechai B						heina S			,	
Aary	2 should and Men is marke	-		. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C									
Baltimore, Maryland 21215-0036	1 and Health tem 27 other t		Barbara L. B	ialy - Wife	20b. Pl		Haddor sition (Name of natory or other		Way, (g, Mary	land 20878
	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	ation 3 Aemoval from State ner (Specify)	*		natory`or other nal Cre		! !	/2009		-	ch, Virgini
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, Item Mance.		21. Signature of Funeral Se	rvice Licensee	n 50	22	. Name and Ad	dress of Fac	cility			, Inc. , Maryla	
8181 60	Physician and Jacob executed as the purial-transit as the purial transit as the purial trange as the purial transit as the purial transit as the purial tr	al Examiner	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	tic Fa s a conseque 1 Fail s a conseque ic Val	Do not enter ailure ence of): Lure ence of): Lve Ste	er the mode of	dying, such	as cardiac or I	respiratory a	rrest,		Approximate Interval Between Onset and Death
17 FEB 09 P.O. Box 68760,	death ce e attendii d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal	death 3	Ectopic pregnion of their (specify				23	d. Date of delive	ry Day Year
ırds,	w requires that the sbeen signed by the should be detached	by	Part II. Other significant co	nditions contributing to death	but not resul	ting in the un	derlying cause	given in Par	t I.				e cause of death? ably 4X] Unknown
\mathcal{R} 1 \mathcal{E} \mathcal{L} Vital Record	The law I	e Completed	25. Was case referred to me	adical				90 51		1 □ Yes	rmed? 2x No	24b. Were autop prior to con death? 1 ☐ Yes	osy findings available apletion of cause of
GAB	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ation: To Be	examiner? 1 Yes 2 KNo 27. Manner of Death 1 Natural 5 Pe	1126-1		R/Outpatient 28b. Time of Injury	28c. lr	74h	280		dence 6	☐Other (Specify)
	ital or Atte	Certification:	4 ☐ Homicide de	ould not be etermined 28e. Place of In building, e									
BIKL	he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier 1 X Cer (Check only 2 Med one) 1 Med	tifying Physician: To the best dical Examiner: On the basis and manner s	of examinati	rledge, death on and/or inv	occurred at the estigation, in m	e time, date ny opinion, d	and place, and leath occurred	d due to the at the time,	cause(s) a date and p	nd manner as sta lace, and due to	ated. the cause(s)
ai		Σ	29b. Signature and title	ertifier C			29c. Lice	ense numbe				signed (Month, D	
	w	-		rson who completed cause of drew Horvath,			,	D0622		h o s 1		uary 17,	
	Stat Registra	re.	31. Date filed (Month, Day,		rar's Signatu	re	orgetow	ni Koa	u, beni	tesaa,	Mary	tand 20	0814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:49 A. Ruby Lee Benton FEB. 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12630 Veirs Mill Road, #503 Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months 216-38-6411 Yrs Director 70 NOV. 19, 1938 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or Itams 23a 20853 12630 Veirs Mill Road, #503 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify: þ Specify: 3 X Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed within tt of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Other Peoples' Homes 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse Harrison Evelyn Bullick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Steven Greer, Son 1704 Henry Road, Rockville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 🕍 Removal from State ŏ permit. Page Department of Important: If any injury or `4XDonation 5 ☐ Other (Specify) Science Care 02/20/2009 Aurora, Colorado 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. M00956 933 Gist Ave., LL, Silver Spring, 20910 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DIABETES YEARS /Medical Due to (or as a consequence of): Examiner **HYPERTENSION** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YEARS Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Box 68760. physician Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has page 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) en een D50678 FEBRUARY 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJEEV BATRA, M.D., 11120 NEW HAMPSHIRE AV. #300, SILVER SPRING, MARYLAND 20904 31. Date filed (Month, Day, Year) State FEB 20

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar		(Certificate		R	leg. No. 2 0 0	3 07111
	Division		Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medio		MAI	RY ROBERTA	BOLLAF	RD		FEB. 1		1:40 A M
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Tov	vn, or Location of Dea	th	4c. County of De	ath
1				GENERAL HOS			LNEY		MONTGO	
П	Funeral		5. Social Security Number	6. Sex 7. Ag 1 ☐ M 2 ဩ F	e (In yrs. last birth	Months D	ear If Under 24 Hrs ays Hours Min	. (Month, Day	; Year)	irthplace (State or Foreign Country)
	Director 		481-16-1917 Usual Residence of Decedent	21	89 ''			NOV. 10	, 1919	IOWA
	ow ow		10a. State 10b. County		10c. City, Town of	or Location				10d. Inside City Limits
	Mary F sh	į	MD. MONTO	GOMERY		SILVER SP	RING			1√∑Yes 2 □ No
	r 28a	Director	10e. Street and Number	JO2112112		10f. Zip Co		1	0g. Citizen of What C	country?
	h with	a D	1007 DOWNS I	OR.			20904		U.S.A	
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent	of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am	erican Indian,
90	or ite		1 ☐ Never Married 2 💢 Mar	ried 1 □Yes 2 🔀 I	No	1 ☐ Yes 2 🔀		no moan, etc.,	Black, Wh	ite, etc.
00	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						WHITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Exar, and must be notified at	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	1 (4	Decedent's Usual O Give kind of work d ife. DO NOT use n	one during most of wo	orking	16b. Kind of Busines	s/Industry
12	withir ene. than	щ	Elementary/Secondary (0-12)	College (1-4or 5	(+)	SECRE	•		OFFI	CE
	filed Hygi ther		17. Father's Name (First, Middle,			DECKE		me (First, Middle, I		CE
Maryland	uld be Mental arked o	To Be	CARL C.	WIEGERT				MARY F	ELLEN KE	NNEY
ary	should and Mer s marke	-	19a. Informant's Name/Relations		19b. N	Mailing Address (Si	reet and Number or F		r, City or Town, State,	
ž	alth a 27 Is 27 Is		ROBERT D. BO	DLLARD/HUSBAN	ND 100	7 DOWNS	DR., SILVE	R SPRING.	MD. 2090	4
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar investible in titled at once.		20a. Method of Disposition			isposition (Name of crematory or other			20c. Location - City o	
Ĕ	Page nent int: If	- 8	1 ☐ Burial 2 🌠 Cremation 4 ☐ Donation 5 ☐ Other (S		1	RS CREMA	i i	8-2009	RIVERDALE	. MD
a <u>t</u> i	rmit. porta y inju		21. Signature of Funeral Service	Bensee /	Olimide	22. Name and A	ddress of Facility			
<u> </u>	83 = 8		MAN. CA	ruberson	M00091	5801 CL	S FUNERAL EVELAND AV	E., RIVER	REMATORIUM RDALE, MD.	² 0737
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. Do no					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Consi	estive	Heart	failur	2		Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	a consequence of)					
	Lxammer	ايدا	Sequentially list conditions	b. Acut	e Ren	iel ta	lune		W//_W	
1	ted sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)	ha chu	11.20	disens	Q	
)	e and	xar	that initiated events resulting in death) Last	c. UUUIII	a consequence of	1/4C/103	c curi	Wisco		
68760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			d						
89	ertificat ling phy e as the	Medical								
Box	eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	۵.			23d. Date of d	elivery
	deat be att	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		3 ☐ Ectopic pregi 5 ☐ Other (special			Month	Day Year
<u>Ч</u>	at the	چ	9 Unknown	9 🗆 Olikilowii						
Ś	w requires that the dispersion is been signed by the should be detached	by	Part II. Other significant condition	ons contributing to death bu	ut not resulting in th	ne underlying caus	e given in Part I.	23e. Did tob		to the cause of death?
Vital Records,	equir sen s	ted						1 □ Y€	es 2 □ No 3 □/1	robably 4 Unknown
e G	elawi hasb e2sh	Completed					·	24a. Was ar	n 24b. Were a	utopsy findings available completion of cause of
		S						perforr	med? death? 2 ☑ No 1 ☐ Ye	
VI të	siclan: The certificate rector, page	Be	25. Was case referred to medical examiner?					ath (Check only on	e)	
	Physical direct	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Impatie		atient 3 DOA			ence 6 ☐ Other (Sp	ecify)
r C	ing Affer	ioi	1 Natural 5 □ Pendin		ry 28b. Tin <i>v, Year)</i> Inju		Injury at Work?	28d. Describe ho	w injury occurred	
<u>s</u>	death death ctor: y the	licat	2 Accident investig	not be 28e Place of Init	ıry - At home, farm		1 ☐ Yes 2 ☐ No	28f Location (St	reet and Number or F	Pumi Pouto Alumbos
Division of	after after Dire	Certification: To	4 ☐ Homicide determ	building, etc	. (Specify)	, street, lactory, on		City or Town	n, State)	narai noute ivalliber,
	e Hospital or Attend 124 hours after death e Funeral Director: /		29a. Certifier 1 Certifyir	ng Physician: To the best	of my knowledge, o	death occurred at t	he time, date and place	e, and due to the c	ause(s) and manner	as stated.
	the Ho hin 24 h the Fu mpletely	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination and/	or investigation, in	my opinion, death occ	urred at the time, d	ate and place, and du	e to the cause(s)
	To the Hosp within 24 ho To the Fund completely f	M	29b. Signature and title of certified		1 1	29c. Lie	cense number		9d. Date signed (Mon	th, Day, Year)
	6) C. Z	0,10		D	67 117		2-17-	-2009
			30. Name and address of person	who completed cause of de	AAI	0 1 0 -1	1 Ston	eral t	lospital	
			Ch want Day Year)	chivily,	Mont	yomer!	J USA	yar r	1047	VEY, MD.
	Sta		31. Date filed (Month, Day, Year)	2000 32 Registra	ar's Signature	Land				-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 2009 Mary Μ. Berley 11:25 № February 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Director 109-18-5489 87 June 26, 1921 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State , or items 23a or 28a-f show 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. It involves arier ueath with the Maryla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be rediffed at once. Director 1 ☐ Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 11621 New Hampshire Avenue 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Mullen Mary O'Connor ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11621 New Hampshire Avenue, Silver Spring, George Berley/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 21, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part / Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of) Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 2 🛮 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 K No 1 ☐ Yes 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 21√2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 K Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed After this

spital or Attendi lours after death. neral Director; A death.

attending pl certificate has been signed by the ector, page 2 should be detached

24 hours a To the within 2

State

Harold V. Lawson, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of per

4 Homicide

29a. Certifier

Medical

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Registrar's Signature



DHMH 17 Rev 1/2001

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D67589

29d. Date signed (Month, Day, Year)

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Box 68760, P.O. of Vital Records,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February Anita Buonaguro 2009 4:11 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖾 F Director 100-18-5413 90 New York 09/09/1918 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show in than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🕅 No Directo MD Calvert Owings 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2601 Red Bud Lane 20736 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify Specify. white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giacomo Gioia <u>Teresa</u> <u>unobtainable</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alfred F. Buonaguro, son Box 13, Brandywine, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/20/2009 Alexandria, VA 22. Name and Address of Facility Signature of Funeral Service Ligen Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death, shock, or he rt lailure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician disease or condition resulting in death) in Know /Medical Due to (or as ercho Vascular Discon Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) burial-t P.O. Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year Day signed by the a d be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Tes 2 No 3 Probably 4 tonknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 Pro Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 🗖 Certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and le of certifie 29c. License number 30. Name and address of person no completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day Year) 32. Registra s Sgnature State 2009 ▶ Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19^{Day} 0^{Month} 20 09 Estelle Blue 6:05 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Co Clinton Southern Maryland Hospital Date of Birth (Month, Day, Year) 11/01/1921 Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 047-34-4935 Min 1 □ M 2 💆 F Months Days Hours Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ¥Yes 2 □ No SC Chesterfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1306 Oakland Church Road USA 29709 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Specifyblack 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Domestic unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Little Louisa Sellers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Piscataway, New Jersey Corina Graham/daughter 208 Morris Ave 20b. Place of Disposition (Name of cemeters crematory of other place)
Mt. Olive Missiona
Chur Ceme. 2/24/09 20c. Location - City or Town, State S. Carolina Chesterfield, 420 H Street I Wash DC 20002 22. Name and Address of Facility 21. Sign, ture of Fur eral Service Licen see BK Henry Funeral Chapel Wash DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ratio respiratory disease or condition resulting in death) EXTENSIVE Gorar myotantial Dyardon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner death certificate be executed Box 68760, P.O. I Division of Vital Records, e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certificaletely filled in by the funeral director. p.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, it e Medical Examiner must be notified as

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event

Physician

/Medical

physician and s the burial-trans

attending pl for use as t

signed by the a d be detached for

cate has been si, page 2 should b

Maryland 21215-0036

To the Hosp within 24 hor To the Fune completely fi Registrar

State

29b. Signature and title of co-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BDSIR MOHM AD F KOLIA MO

29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DOO 28035

2009

31. White med (Month, Day, Year)

and manner stated.

MD

			For State Registrar	State of M	larylan		artment of rtificate of		and Mental Hy	giene Reg. No. 20	09 07116
	Physici /Medic		Decedent's Name (First, Middle, L	Mar		itner			2. Date of De Month Februa		3. Time of Death
1	Examir	ner	4a. Facility Name (If not institution, g 21314 Leitersbu 5. Social Security Number 6.	rg Pike		last birthday)	4b. City, Town, Ha If Under 1 Year	gersto	wn		ington
	Funeral Director		214-42-1209 Usual Residence of Decedent	1 □ M 2½ F	65	Yrs.	Months Days		Min. (Month, D	ay, Year) 24,1943	9. Birthplace (State or Foreign Country) Maryland
	th the Marylar or 28a-f show e notified at	Director	10a. State 10b. County Maryland Washi 10e. Street and Number	ngton	10c. Cit	y, Town or Lo	Hager	stown		10g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2√√ No /hat Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinar must be notified at	by Funeral	21314 Leitersbu 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 _ Types _ 2 Ty If Yes, Give Year or Dates	? No				gin? (Specify Yes or No Puerto Rican, etc.)	U.S.2 14. Race Black Specify:	e - American Indian, k, White, etc.
21215-0036	within 72 hou iene. than "natura"	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5+)	16a. Deced (Give life. L	dent's Usual Occu kind of work done DO NOT use retire HOME1	during most ed)	of working	16b. Kind of Bus	siness/Industry
Maryland 2	ould be filed I Mental Hyg narked other latic event, II	To Be Co	17. Father's Name (First, Middle, Las	ox, Jr.				18. Mother	r's Name (First, Middle	, Maiden Surname E. Law	7
Ž	1 and 2 Health a em 27 is		19a. Informant's Name/Relationship Riley Bitner II 20a. Method of Disposition			21314	Leiters	burg l	r or Rural Route Numb Pike Hager: Date	stown, MI	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		1 Burial 2 □ Cremation 3 I 4 □ Donation 5 □ Other (Spec	ify)		Cemeter 22	. Name and Addr	ess of Facility	U.L. I	Hagers Davis Fur	stown, Maryland neral Home Maryland 21783
	The law requires that the death certificate be executed EX NAME Step has been signed by the attending physician and a large 2 should be detached for use as the burial-transit and a large and a l	edical Examiner	23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a: Due	ine. S a consequence a conseq	,	er the mode of dy		cardiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
.O. Box	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (Mo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗆 Fetal	death 3	Ectopic pregnan Other (specify)	су		23d. Date Mon	e of delivery hth Day Year
ords, P.	w requires that the dispersion is been signed by the should be detached	Completed by Ph	Part II. Other significant conditions	contributing to death	out not resu	ulting in the un	nderlying cause gi	ven in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
			Chronic C 25. Was case referred to medical examine?	believe		Puh	, De	Land 26. Place	24a. Was auto performed 1 Tyes of Death (Check only of	psy promed? de 1	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 □ No
Division of V	tending Phy leath. tor: After this the funeral di	ertification; To B	27. Manner of Death 1 Deatural 2 Accident 3 Suicide 4 Homicide	28a. Date of Inj (Month, Date on 28e. Place of In	ury ay, Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo	ner: 4 □ Num ry at rk?]Yes 2 □ N	lo	how injury occurre Street and Numbe	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Exa	hysician: To the besi miner: On the basis and manner s	of examina	wledge, death tion and/or inv	estigation, in my	opinion, deati	d place, and due to the h occurred at the time,	date and place, a	nd due to the cause(s)
	7 ¥ 6 0	Z	29b. Signature and title of suffer 30. Name and address of person who	completed cause of	death (Hem	-23a) (Type [Print)	0050.	362	29d. Date signed	(Month, Day, Year)
	Sta Begistr	te	Vincent Cantone, 31. Date filed (Month, Day, Year)	22911 Jef	ferso	n Blvd	l., Smith	isburg ,	, MD 21783		

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DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended #12, 18, 19a&b per FH FCH Frificate of Death JV 2/24/09 Reg. No. 2 Date of Death
 Month **Physician** 16, 2009 ROBERT NELSON CAMPBELL February 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 904 Cherokee Trail Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Months July 23. 216-38-2399 66 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ∏Yes 2 □ No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or se within 72 hours after death with 904 Cherokee Trail ral", or items 23a e Examiner must b 21701 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1961 – Black, White, etc. 1 Never Married 2 Married Specify: White 1980 Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Yes Give þ 3 ☐ Widowed 4 🏋 Divorced Year or Dates: 73-80 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Military U.S. Government 12 should be filed w h and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie A. Whitbeck Annie Amelia Whitbeck Howard Cornelius Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Keith Campbell / Son Daughter 9330 Hillsborough Drive Frederick, MD, 217011043

Ice of Disposition (Name of Date 20c. Location - City or Town, State Saltimore, Deborah Ann Campbell Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ' 1X Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem. Gardens 2/20/09 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature Fineral Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final therosclerotic **Physician** ea disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-trans and Due to (or as a consequence of) Box 68760, attending physician pe Physician/Medical as the t IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Tyes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kohver

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State

Registrar

31. Date filed (Month, Day, Year)

FEB 20

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month February 20 2009 S 3:40 P Edward Casey /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours 214-32-2009 Director 9/28/1926 82 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho MD FREDERICK Director FREDERICK 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or items 23a or y 500-B PATTON CIRCLE USA Funeral 21703 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 2 1 ☐ Yes 2 💟 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed : If Item 27 is marked other than "nature or other traumatic event, It a Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NATIONAL Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE PARK SERVICE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL GEORGE CASEY ပ ROSE HARTMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO ANN CASEY/WIFE 500-B PATTON CIRCLE FREDERICK, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of I Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREAMTION: 2/23/2009 | STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 370 W. CYPRESS ST. MILLINGTON, MD 21651 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) PSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐ Pregnant at time of death 9☐ Unknown Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Disease Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital မှ 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA After the 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours aren within 24 hours aren To the Funeral Director: Aftrownlately filled in by the fur Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) dino 8

Registrar DHMH 17 Rev 1/2001

State

bardo

Frederick MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanky

31. Date filed (Month, Day, Year)

Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician Month Day Janice Austin Cook 1114 AM 20-2009 02 -/Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Coastal Hospice at Salisbury Lake If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 090-20-6248 Months Days Hours Min 1 □ M 2**X** F 82 Director 04/24/1926 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Exeminat must be rectified at Director 1 ∏Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? 806 Camden Ave. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: ۾ Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ librarian library 12 1 and 2 should be filed w Health and Mental Hygier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Lucille Cuthbert James Curtiss Austin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Cook/husband 806 Camden Ave., Salisbury, MD 21801 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of F Important: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/23/09 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kall R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE **Physician** CHRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buts after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2. ☐Ño P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence State (Specify) Hospic 12 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 □ No 2 Accident 1 Tyes 6 ☐ Could not be 3 ☐ Suicide

State

Registrar DHMH 17 Rev 1/2001 HOSPICE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10057410

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

COASTAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

-Husten warns

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** iq, R. Cavanaugh 10:15 AM 2009 eb: /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Wicomico Salisbury Rehabilitation & Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last dirithday) Salisbun or 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Sex 1 ☐ M 2 X F **Funeral** Year) Months Days Hours Min Yrs. 3-4-1918 **Director** 234-30-9177 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21804 Funeral 31880 Bonhill Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2X No If Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 📉 No White Specify: ģ 3 N Widowed 4 □ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufactor 12 Riveter Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberts Wilsie Thompson ဥ Harry 19a. Informant's Name/Relationship *(Type. Print)* daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances L. Brittingham -31880 Bonhill Drive, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-2009 Hebron, Maryland 4 Donation 5 ☐ Other (Specify) Springhill Memory Gds 22. Name and Address of Facility Bounds Funeral Home 21. Ignature of Funeral Service Licensee. 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician co eaco disease or condition resulting in death) ser Due to or as a consequence of): /Medical Examiner ypa. Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ certificate has been sign irector, page 2 should be 1 | Yes 2 4 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 🗖 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a, Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ind manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies

Ach

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Ma,

State Registrar

DHMH 17 Rev 1/2001

William H.
31. Date filed (Month, Day, Year)

200 Civic Ave. Salisbury

En

Robins M.D.
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-01633 Agnes Cooper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1-For State Certificate of Death Certificate of Death Reg. No. 0.00.00	
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death	Time of Death 2
	4a. Facility Name (frot institution, give street and number) 4b. City, Town, or Location of Death Harrisville Road 4c. County of Death Woolford Dorchester	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthp Count Months Days Hours Min. Sept. 16, 1934 Usual Residence of Decedent	
yland -f show any one.	10a. State 10b. County 10c. City, Town or Location	0d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at one.		<i>y</i> ?
er death w , or items r must be		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	lustry
21 be fill ntal I rked ent,	Joseph Chester EMMa Cornish	
nore, MD 21 ages 1 and 2 shou d nt of Heatth and Me t: If item 27 is n a other traumatic v	19a. Informant's Name/Relation'ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 19c. Method of Disposition 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 1509 - Winters Court Cambridge, N 20a. Method of Disposition 20b. Place of Disposition (Name of cemeiery, Date 20c. Location - Dity or Town)	
Baltimore, permit. Pages I at Department of Hee Important: If ite Injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Malone Cemetery 3/7/09 Madison	, MD.
Physician		D. 2/6/3 Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypothermia Due to (or as a consequence of):	Death
led nisit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
760, frate be executed physician and the burial - transit Medical Exa	events resulting in death) Last Due to (or as a consequence of): d. XUNPENDED AMENDED PI line a-b, PII, 27,28a-f,perME, g891 5/13/09 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	/ Year
s, P.O. Bo irres that the dea is signed by the a d be detached fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive atheroscleortic cardiovascular disease 1 Yes 2 No 3 Probable	
Division of Vital Records, as after death. In or Attending Physician: The law requires as after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	Demontiate characteristics and Improve discoss 24a. Was an 24b. Were autop	psy findings available apletion of cause of
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical examiner? 1 V Yes 2 No Cother: Sc Residence 6 V Other: Sc Residence	cene
Division of Vital or Attending Physical or Attending Physical and Director: After the liled in by the funeral ertification: Teering	27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Subject exposed to environment	cold
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in be	3 Suicide 6 Could not be determined (Specify) Wooded area 286. Location (Street and Number or Rural or Town, State) Harrisvill (Specify) Wooded area 287. Location (Street and Number or Rural or Town, State) Harrisvill (Woolford, MD)	
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cades(s) and manner as stated. and manner stated.	
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, February 26, 2009)	Jay, Year)
State	Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Registrar	31. Date filed (Month, Day Year) ARK 05 2009 32. Registrar's Signature	

OCME 2006

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Joanne Mary Coty February 24, 2009 4:20 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital eonardtown If Under 1 rem If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F New York Director 063-18-8301 83 07/08/1925 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 XYes 2 ☐ No Director Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21585 Peabody Street Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itee any or other traumatic event, the IN-alical Extention 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ, Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Brainard Thomas Earl Coty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Randy Boatwright/Son Department of Health Important: If item 27 any injury or other trong. 23181 Falling Leaf Lane, California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cre 02/27/2009 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Chashawn Aylesworth M01521 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meymonig **Physician** /Medical Due to (or as a consequence of) Examiner epsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of) Examiner Hypotension The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a donsequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hy Parlipidemis Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Demento 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 ☐ Accident 5 ☐ Pending investigation after death.

Director: A in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dir Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 00062213 24 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh H. Patel mp 22650 Syresh MD 22650 Cedar Lane Court, Leonardtown, MD 31. Date filed (Month, Day, Year) FEB 27 2009 2. Registrar's Signature State Registrar

JOANNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 18, 2009 **COOPER** 1:00 P.M Arno1d /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Feb. 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 937 Bronx, Hours Months Days Min. 1 XM 2 □ F 71 112-28-1030 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mast be rudified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No **Funeral Director** MD Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 12001 Trailridge Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Scientist Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Lander Joseph Cooper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12001 Trailridge Dr., Potomac, MD 20854 19a. Informant's Name/Relationship (Type. Print) Adele Cooper / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State Garden of Remembrance Feb.20,2009 Clarksburg, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fune of School 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 days Septic Shock /Medical Due to (or as a consequence of) **Examiner** Respiratory Failure 10 days Sequentially list conditions Due to for as a conse quence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure 10 days Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Perforated diverticulitis 2 weeks Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 24 hours after death.

2 hours after death.

2 Funeral Director: After this certificate has been signed by the letely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Funer (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Feb. 18, 2009 29b. Signature and title of certifie 29c. License number D0066716 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, MD 20850 Ramaseshan , Sujatha 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1- Registrar AMEND#23a(a)per,MD,2/24/09,EMW,MoodCertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Edward Michael Campbell February Ί6, 2009 8:35 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2824 Blue Spruce Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 26, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days XXM 2□F Months 217-84-9596 47 1961 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐Yes 2 TNo al", or items 23a or 28a-f sl Examiner must be notified Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 2824 Blue Spruce Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemi Black White etc. 1 Never Married 2 Married 1 ☐Yes 2 X No Specify. White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CPA Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Michael Campbell Rose Majeskie ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pauline B. Campbell/Wife 2824 Blue Spruce Lane, Silver Spring, MD 20906 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 2009 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) ancer **Physician** Pha /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ilitated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to þ Be Completed မ Certification: After after death

Director: /

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, n 24 hours aft ie Funeral Di bletely filled in To the Hosp within 24 ho To the Fune completely f

the Maryland

death with

Baltimore, Maryland 21215-0036

Part II. Other significant conditions c	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.		se contribute to the cause of death? ¶No 3□ Probably 4□ Unknown			
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No			
25. Was case referred to medical			26. Place of De	eath (Check only one)				
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	DOA Other: 4 In Nursing	Home 5 Residence	G ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred			
	6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysician: To the best of my knominer: On the basis of examinand manner stated.				and manner as stated. I place, and due to the cause(s)			
29b. Signature and tile of certifier			29c. License number	29d. Daj	e signed (Month, Day, Year)			

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Samuel Ray Denmeade,

401 North Broadway, Baltimore, MD 21231

State Registrar

Medical

31. Date filed (Month, Day, Year)

32 Registrar's Signature

20

09-01554 William Edward Collins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 07127

			For State	,	Certificate o	f Death			Reg.	. No.	
Physic		1.	. Decedent's Name (First, Middle,Last			1000	1	: /	Date of Death Month	Dav Year	3. Time of Death 0829 hrs
ledical Exan	niner		William Edwa		S	4b. City, Town, o	a Langtion of		ebruary 22	4c. County of I	
		4	a. Facility Name (if not institution, given Calvert Memorial Hospital			Prince Fre	**			Calvert	500
Funera		5	. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Ye		Min		F	9. Birthplace (State or Foreign
Directo			215-23-0409 1 <u>X</u>	M 2 F 23	Yr		lys Tiours		11-15-1	.985	Country) MD
		_	Usual Residence of Decedent Oa. State 10b. County	110c.	City, Town or Loca	ation					10d. Inside City Limits
nd show any			MD Calver		,	Chesap	eake E	Beach			1 Yes 2 X No
Marykand 28a-f show	Director	1	0e. Street and Number			10f. Zip Code			- 10g	. Citizen of Wha	
the N	MD Calvert Criesa 106. Street and Number 106. Street and Number 3202 Burgess Road 20									USA	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Ket other than "unatural", or items 23a or 28a-f she		1	1. Marital Status 1. X Never Married 2 Married	12. Was Decedent Ever Armed Forces?	If	as Decedent of I Yes, specify Cub	lispanic Origi an, Mexican,	in? (Spec Puerto Ri	can, etc.)	14. Race - White,	American Indian, Black, etc.
er dea	1 2			1 Yes 2 X	No 1	Yes 2 X	lo specify:			Specify:	white
urs aft tural'	d b	1	15. Decedent's Education (Specify o	for Dates:		ent's Usual Occup				16b. Kind of Busi	iness/Industry
72 hor "na	ete	r	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of working li	te. DO NOT I	use retired	2)		
5-0036 lted within 72 hours after Hygiene. Lother than "natural", the Modical Francians.	Completed	L		1	stu	dent	I do Markani	- Nama (F	iret Middle M	aiden Surname)	
15-0 filed v I Hygi	i S		17. Father's Name (First, Middle, Last William Alber				1	leen		Sullivan	
21215 ould be filt Mental H	To Be		19a. Informant's Name/Relationship (eet and Num	ber or Ru	ral Route Numb	er, City or Town,	, State, Zip Code)
AD 2 shc 2 shc 27 is			William A. Colli	ns, father					sapeake	e Beach,	MD 20732
2 2 2 2		2	20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. Place of Disportant		cemetery,	ı	Date	20c. Location - 0	City or Town, State
Pages			4 Donation 5 Other Specify		Metropol	itan Cre	matory				dria, VA
Baltimore, permit Pages 1 a Department of He Important: 10 iti	a land	12	21. Signature of Funeral Service Licer			Name and Addre					ome, P.A.
		1	23a. Part I. Enter the disease, or com	Directions that caused the	death Do not enter	325 Mt.	Harmon	ny La ardiac or r	ne, UWI	tngs, MD st. shock, or hear	rt Approximate Interval
Physicia Medica			failure. List only one cause on e	ach line.							Between Onset and Death
xamine	er		Immediate Cause (Final disease a or condition resulting in death)	Due to (or as a conseque		CIOII					
	١.		Sequentially list conditions, b				4				
	iner		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):						
	nsıt Examiner		(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
760, cate be executed physician and	ct		d d	AMENDED 23a,P	TT.27.28	a-f. per	ME. g8	389 3	710/09	TT	
- au e	he burnal - tr Medical	L	X UNPENDED	V			, ,			23d. Date of o	delivery
8760, ifficate be	-		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o		Fetal death	3 Ectopio	c pregnan	су	Month	Day Year
Box 68's death certiff	for use as	2	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at time	- 5 -1 41-	Other (Specify)				1	
Bo he dea	Sched to		Part II. Other significant conditions	9 Olikilowii	t not resulting in th	e underlying caus	se given in Pa	ert I.	23e. Did tol	bacco use contrib	bute to the cause of death?
cords, P.O. Box 68 law requires that the death certif has been signed by the attending	detac	3	Cocaine use	Contributing to death bu	Thorresonang ar ar	o and onlying sauc	g		1 Yes	2 No 3	Probably 4 V Unknown
ds, equire	completed	201							24a. Was a		Vere autopsy findings available
COF law r	e 2 sh	5							autops perfor	med? de	rior to completion of cause of leath? Yes 2 No
tal Rection: The	or, pag		25. Was case referred to medical			26.PI	ace of Death	(Check or		2	163 2 110
/ital	directo	ĎΙ		Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 🗸 DOA	Other ₄	Nursing	Home 5	Residence 6	Other:
of \ing Phy	meral dir		27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time o		njury at Work		_	now injury occurre	ed
ion tendin eath.	the fu		Natural 5 Pending Accident Investiga	Fd 2/22/0	9 Fd 5:	30 am	Yes 2X		ınk ———		
Division of Vital Records, P.O. tel or Attending Physicien: The law requires that the reacher death. al Director: After this certificate has been signed by	illed in by the fune	<u> </u>	3 Suicide 6 X Could no determin	ot be 28e. Place of Injury	- At home, farm, st	treet, factory, office	ce building, e	tc.	or Town, S		er or Rural Route Number, City
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending	completely filled in by the funeral director, page		(Check only one) 2 Medical Examine	er:On the basis of examina	ation and/or investi	gation, in my opir	nion, death or	ccurred at	the time, date	and place, and di	ue to the cause(s)
To To	TIOO N		29b. Signature and title of certifier	and manner stated.			ense number				ed (Month, Day, Year)
			Yamel Divition	y man		0.	C.M.E.			February 2:	3, 2009
		+	30. Name and address of person who						D 04004	•	
			Pamela E. Southall, MD	Assistant Medica		111 Penn Str	eet, Baltin	nore, M	D 21201		
	Stat	le	31. Date filed (Month, Day Year)	2009 32. Registrar's S	signature	faces					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ANCY OFFREN 2130 М 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sept. 22 1924 Social Security Numbe Months Days Hours 219-12-4309 1□ M 2 F 84 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Calvert Broomes Island 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20615 United States 4150 Penkert Lane 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aloysius Patrick Geary Ruby Adelaide Good 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8315 F Street Chesapeake Beach Maryland 20732 Pamela Coffren Sands-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 26^{Date}2009 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Cheltenham Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Foneral Service Licenses 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; If item 27 is marked other the any injury or other traumatic

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

Funeral

Director

show

ir than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at

death

72 hours after

Baltimore, Maryland 21215-0036

and burial-tran the attending physician the 0 ģ signed I þe peen has page 2 certificate

Physician/Medical

δ

Completed

Be

2

Certification;

Medical

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

٥

after death.

Director: After this filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?

24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) DICE House 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 ☐ Suicide 4 ☐ Homicid	
29a. Certifier	147 C

Natural

2 Accident

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

(Month, Day, Year)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier	í
DAA'	1
77 VV (W)	1

5 Pending investigation

W

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

<u>drni</u>	12	
	St	ate
	Daniel	

within 24 hours a To the Funeral I

W É al 32. Registrat's Signature 31. Date filed (Month, Day, Year) 09 > 19

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH C889 3/30/09 TH of Health and Mental Hygiene 2009 For 2-23-09
State 2-23-09
Registrar Amenda # 's4a, 4b, PerPhys, Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 02 - 11 - 0917:02EDWARD CAUTHEN /Medical 4b. City, Town, or Location of Death
Clinton
Fort Washington 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Millennium Winsing w kend Hespita⊥ Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-21-1916 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1₽M 2□F 92 Lancaster, SC Director 578-12-8952 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, his Medical Examinar must be notified at 10a, State Yes 2 No Director Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with **USA** 20744 12021 Livington Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or ite
Iry or other traumatic event, the Medical Event in 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 □Yes 2 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa McKles John Cauthen ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claudia John/guardian Camp Spring, MD 20748 6420 Allentown Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mary Land

Vet.Cem. 20c. Location - City or Town, State 20a. Method of Disposition Date Gl**Quantico, Virginia** 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 Dother (Specify) 02/26/09 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01246 Cedar Hill FH 4111 PA. Ave. Suitland, MD 20746 Tack Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each | e. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** week disease or condition resulting in death) /Medical to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine insequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ξ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No 1 ☐Yes 2 ☐ No after death.

Director: After this certific
d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☐ Ye,s 1 DInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft ie Funeral Di oletely filled ir 29a. Certifier l 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Function

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Date filed (Month, Day, Year)
FEB 2 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer **Physician** 00/20 BM 2020 M. Hon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1300 3 Torrecal If Under 24 Hrs. Biphplace (State or Foreign Country) If Under 1 Months 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours 1 X M 2 □ F 17, Director 198-24-9706 1933 Pennsylvania Apr. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2√ No Director Fairfax Herndon VA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 13230 Poener Place 22170 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. importent: if item 27 is marked other than "natural", or item any injury or other treumatic event. The Medical Ferror 1 ☐ Yes 2 ☑ No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 4 Tax Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Doppelt Bernard Carb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13230 Poener Place, Herndon, Virginia Alan Jay Carb - Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State Agudas Achim Cemetery 2/23/09 Alexandria, Virginia 1.4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Jefferson Funeral Chapel 21. Sign ture of Funeral Service Lice ▶ 5755 Castlewellan Dr.,Alexandria, Va. 22315 lnure annis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Butery Conson /Medical resulting in death) Due to (or as a consequence of): Examiner Due to (r s a consequence of): Sequentially list conditions, if any, leading to immediate cause E. Ital U. John in Cause (Disease or injury Examiner burial-transit Due to (or as a onsequence of): and that initiated events The law requires that the death certificate be execu resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 5 Other (specify) signed by the a ⊇Yes 2 Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No Gustractont Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an homas has page 2 autopsy performe 1 ☐ Yes 2 ☐ No £: 6 1 ☐ Yes 25 No C.T. or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1. Natural 5 Pending 1 TYes 2 No investigation death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature. FEB 2 3 2009

20853

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, 2009**Physician** February 2038 Marie Elizabeth Chadwick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital E1kton If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F Director 59 April 7, 1949 Delaware <u>221-34-5849</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director North East Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 United States 318 Lakeside Drive permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No If Yes, Givo Year or Dates: 3 ☐ Widowed 4 X Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Floor Associate Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Joseph Casapulla Mary Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Chadwick/Son 316 Red Pump Road, Nottingham, PA 19362 March 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Nottingham, PA 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer of Colon unknavn Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine to the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Otle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2.26.2009 Jackoby 5 MB 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 A, E +ugh St S.S SACHDEN MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Cleavenger Lucian Lanie 2009 March 12 Noon M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Golden Living Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 7 1912 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral X**□M 2□F West Virginia 96 578-07-2385 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shown any injury or other traumatic event, the Medical Event. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 □Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 U.S.A. 12710 Winchester RD SW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No 1944 If Yes, Give 1944 Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Bldg. Inspector - Carpenter Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie (VanGilder) Cleavenger Zack Cleavenger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 437 Independence St., Cumberland, MD Nelson O. Cleavenger Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State MD Veterans Rocky Gap Mar 5,2009 Flintstone, MD of Funeral Service 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD th. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Enter the disease, or , or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** don Due to (or a a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Cisease or light Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trar and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ate has been sign page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. Beverly Calkins M.D., 500 Memorial Ave., Cumberland, MD

32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0054411

29d. Date signed (Month, Day, Year)

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Helene Α. Dunn /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month; Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛣 F Months Director <u>302-34-2389</u> Jun 26, Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Evention is ust be notified at Director 1 ☐ Yes 2 No MD Howard Ellicott City filed within 72 hours after death with the 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 11829 Triadelphia Road 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Specify ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than 'ury or other traumatic event, Ins. Ma. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Krenzer Eleonore Dormann ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11829 Triadelphia Road Ellicott City, MD 21042 Donald J. Dunn/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Arundel Crematory 02/21/09 Odenton, MD 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Bever Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, *o*utcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time *o*f death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month 5 ☐ Other (specify) signed by the a 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 □ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Sa 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2009 6:06P M February George Arthur Daigneault 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Feb. 24, 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Hours 80 1928 Maine **Director** 722-12-4533 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual met must be notified at Frederick Thurmont 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14809 Sabillasville Road 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 1945 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No 1945-65 Specify White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liaison Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be St.Jacques Daigneault Rhea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thurmont, MD 21788 Marilyn Daigneault/Wife 14809 Sabillasville Rd, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/07/2009 | Arlington, VA Arlington Nat. Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA e of Funeral Service Licenses 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vennaly /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deal

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy his certificate hil director, page 1 □Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. ture and title of certifier 29b. Siona 29c. License number 29d. Date signed (Month, Day, Year) D0067210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W. Seventh Street, Frederick, MD 21701 Ronit Knirbat 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 20 pare Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie ()

		Certificate of Death	nomai my	Reg. No.	9 07133
		1. Decedent's Name (First, Middle, Last)	2. Dete of De Month	eeth	3. Time of Death
Physic /Medi		FANNIE C. DODD	02	18 20	009 12:55PM
Exami		4e Fecility Name (If not institution, give street end number) 4b. City, Town, or L	ocation of Deat	th 4c. County of	of Death
		6256 Galestown-Reliance Rd Seaford Seaford Seaford Foodal Search Number 6 Sea 7 Ang / In urs. lest birth/fav) If Under 1 Year If Under 24 Hrs.			hester
Funeral		5. Sociel Security Number 1 M 2875F Vrs Wonths Days Hours Min.	8. Date of Bi (Month, D		9. Birthplace (State or Foreign Country) N
Director		213-05-4699 96 Usuel Residence of Decedent	12-20-	-1912	Maryland
ylend		10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mar a-f st	ţo	Maryland Dorchester Seaford			1 ☐ Yes 2 ☐ No
or 28	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of W	hat Country?
efter death with the Maryland or items 23s or 28s-f show prines must be notified at	ral	6256 Galestown-Reliance Rd 19973		US	A
	Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?)	Rican, etc.)	o- 14. Hace Black	e - American Indian, k, White, etc.
is effective.	by F	1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 🛣 ☐ No If Yes, Give 1 ☐ Yes 2। No Specify: Yeer or Dates:		Specify:	white
within 72 hours efter desence. ene. than "naturel", or frome	8	15 Decadent's Education 16a Decadent's Usual Occupation		16b. Kind of Bu	siness/Industry
	ple	(Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired] [Ife. DO NOT use retired]	ang	7	1 0 - 1
d with	Completed	2 Bookkeeper			nd Grain
be filed within tel Hygiene.	Be			e, Maiden Sumame	9)
Mer die	٩		e Murp		
VICIT 12 sh h end h end r is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru Faye A. Hurst - daughter P O Box 236, Vienn			State, Zip Code)
Healt Ther		20h Place of Disposition (Name of	Date		City or Town, State
omit. Peges speriment of sportant: If Its ny injury or o		cemetery_crematory or other blace)	/21/09	Federa	alsburg, MD
permit. Depentimports eny inju		21. Signature of Furieral Service Licensee John A. Cranston 22. Name and Address of Fecility Cranston Funer P 0 Box 967, S			0.73
		23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,	Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth) a. End Stagl Pens Desase Due to (or as a consequency of):		,	Onset and Death
octob cele be executed physician and sthe burial-transit	cal Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	ypira 12	y .	
5 6	2	that initieted events resulting in death) Last Due to (or as a consequence of): d.			
deat death	SICE	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use con	tribute to the cause of death?
bet the	by Physician/	Dementia (Senile, Algherners type)	1□	Yes 2□ No	3 Probably 4 Unknown
lev requires thet the death certies been signed by the ettendin as been signed by the ettendin a 2 should be deteched for use	Completed by		24a. Wa	s an autopsy formed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
VICAL THE SIGNATION OF STREET OF STR	E		1.	Yes 2 No	1 ☐ Yes 2 ☐ No
VICAL clan: T centificel ector, p	Be	25. Wes case referred to medical examiner?	th (Check only	rone)	
Ol VII.d Physician: this certific real director,	2	1 ☐ Yes 22 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing H		sidence 6 DOthe	
Attending Pl	atlon:	27. Menner of Death 28e. Dete of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury et Work? 1 Yes 2 No	28d. Describe	how injury occurr	∌d
그 등 등 교	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number own, State)	er or Rural Route Number,
Hospital n 24 hours n Funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date end place 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date at the time	and due to the rred et the time	e cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)
To th To th	¥	29b. Signature end title of pertifier 29c. License number	081	29d. Date signed	(Month, Dey, Year)
6-0-1		· ///// (100030	107	02/23/2	009
Deby		30. Name and address of person who completed dugs of death (Item 23a) (Type, Print)	DE 705	7.7	
		Marie Wolfgang MD, one Cedar Ave, Seaford, 31. Dete filed (Month, Page Year) 32. Registrer's Signature	DE 199	1/3	
St	ate	31. Dete filed (Month, FEB 3 300) 32. Registrer's Signature B. Sark			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death **Physician** Thomas George Dutch, Sr. February 12, 2009 17:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**K** M 2□ F Hours Min. 66 Director 579-54-0495 01/31/1943 DC Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Prince George's Suitland [] 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or; any Injury or other traumatic event, the Michael Even fiver must be no once. 3406 Woodcreek Drive 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Baker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ James Edward Dutch Martha Wormley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian L. Dutch/Wife 3406 Woodcreek Dr., Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 Toremation 3 Removal from State 1 D Burial 2/24/2009 5 Other (Specify) Chesapeake Beltsville, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2X No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day, Year)

cause of death (Item 23a) Type, Print Clinton, MD. 20735

and manner stated

Robert Ernest Daughton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 0 9 State of Maryland / Department of Health and Mental Hygiene

		For State		Certificate	of Death			Reg No.	
Physician/ Viedical Examine	1	Decedent's Name (First, Middle,Last) ROBERT ERNEST I	DAUGHTON				2. Date of De Month February	eath Day Yea / 28, 2009	3. Time of Death 1816 hrs
District the	4	a Facility Name (if not institution, give s Upper Chesapeake Medical			4b City, Town, Bel Air	or Location o	f Death	4c County of Harford	of Death
Funeral Director	5	Social Security Number 6. Sex 1X N	7. Age (In y	ıs. last birthday)		ear If Under ays Hours	7 24Hrs. 8 Date of E	,	9 Birthplane (State or Foreign Co Maryland
ow any	_	Isual Residence of Decedent Oa. State 10b. County MD Harford	10c. (City, Town or Lo Whitef					10d Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f shownotified at once. al Director	1	0e. Street and Number 2220 Whiteford Ro	L De		10f. Zip Code 21 1			10g Citizen of Wh	
cr death wi	1	Marital Status Never Married 2 X Married Widowed 4 Divorced III	12 Was Decedent Ever I Armed Forces? 1 Yes 2 X		If Yes, specify Cul		in? (Specify Yes or N Puerto Rican, etc.)	V/hite	e - American Indian, Black, e. etc. Vhite
5-0036 led within 72 hours afti Hygiene of ter than "natural" the Medical Examine Completed by	-	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	or Dates.	during	dent's Usual Occu g most of working rpenter			16b. Kind of Bu	usiness/Industry
21215-0036 Mald be filed within 7 Mental Hygiene marked other than everut, the Medical	3	7. Father's Name (First, Miodle, Last) Royston E. Daught	on			E	s Name (First, Middle Barbara An	ne Scott	,
TOFE, MD 2121 ages I and 2 should be fi nt of Health and Mental it. If item 27 is marked other traumatic event, TO BE	2 1	9a Informant's Name/Relationship (Type Royston E. Daught	on/Father_	222	20 White:	ford Ro	ber or Rural Route Noad, White	ford, MD	21160
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		Oa. Method of Disposition XBurial 2 Cremation 3	Removal from State	crematory of St. Mar	position (Name of r other place) y s Ceme	tery	3/5/2009		City or Yown, State
	L	21. Signature of Funeral Service (cense 23. Part I. Enter the disease, or complice	20-]		Funera	l Home, 60		
Physician /Medical Examiner		failure. List only one cause on each immediate Cause (Final disease a N	ations that caused the di n line. arcotic (he ue to (or as a consequen	roin) i			ardia. Or respiratory a	arjest, snook, or he	Between Onset and Death
led Insit		cause. Enter Underlying Cause	ue to (or as a consequen						
executed an and al - transit		d	ue to (or as a consequen		, perME,	g889 :	3/18/09 TI		
760, icate be physiciathe burn the burn		F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy	Fetal death	3 Ectopic		23d Date of Month	f delivery Day Year
P.O. Box 687 that the death certifined by the attending detached for use as the Physician.	iysicidi	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time	of death 5	Other (Specify)	- Lotopie			
P.O. Be res that the de signed by the be detached if hy Phy	2	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cau	se given in Pa		fes 2∏No 3	ribute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attended property filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director. Page Completel by Physical Control Contribination: To Be Completel by Physic	aladino						1 ✓ Yes	opsy rformed?	Were nutopsy findings available prior to completion of cause of death? Yes 2 No
ician: ician: certif	ין ע	25. Was case referred to medical examiner?	spital:	≥ ✓ ER/Outpat		Other;	(Check only one) Nursing Home 5	Residence 6	Other
ing Phys fing Phys After thi funeral di	- -	1	28a. Date of Injury (Month, Day,Year)	28b. Time	of Injury 28c	Injury at Work Yes 2 X	? 28d. Descrit	be how injury occur	
Division o spiral or Attending nours after death eneral Director: After filled in by the fune Contification:	TILICAL	2 Accident Investigation 3 Suicide 6 X Could not be determined	28e Place of Injury -		street, factory, offi			(Street and Numb State) 2220 Ord, MD	per of Rural Roulo Number City Whiteford Rd
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate i completely filled in by the funeral director, page		one) 2 Medical Examiner:	n: To the best of my kno On the basis of examinat	wledge, death o	ccurred at the time	e, date and pla nion, death oc	ace, and due to line ca	use(s) and manna	r as stated.
To WHI	Me	29b. Signature and title of certifier	And manner stated			ense number		29d Date sign March 1, 2	ned (Month, Day, Year) 2009
		Name and address of person who con Jack Titus MD. Deputy C	ompleted cause of death chief Medical Exam		Penn Street, I	Baltimpre,	MD 21201		
Stat		31. Date filed (Month, Day, Year)	32 Registrar's Si	gnatu	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Sylvester I. Despanza 18,2009 Februa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Months Hours 436-26-1918 1/30/1925 Director Louisiana Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Marylan 10a State 28a-f show traumatic event, the Madical Examinar must be notified at tyE Yes 2 □ No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 20748 USA or items 23a 8601 Temple Hills Road #59 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ IYes 2 □ No 194
If Yes, Give
Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1942 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 1943 American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than $\overset{\text{Elementary/Secondary (0-12)}}{10}$ College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygien.
Important: If item 27 Is marked other the any injury or other traumatic event, Italy once. Car Cleaner Amtrak 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Sylvester I. Despanza, Sr. Louise Moise ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8601 Temple Hills Rd #59, Temple Hills, MD 20748 Robin E. Despanza - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 2/23/09 Brentwood, MD 22. Name and Address of Facility Fort Lincolr Funeral Home 21. Signature of Juneral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death m mediate Cause (Final disease or condition resulting in death) Cardio bulmmany **Physician** /Medical Due to (or as a consequence of) Examiner months Carcinom lastake Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ atnalotitorillation 1 Yes 2 No 3 Probably 4 Unknown Completed rabetes melletus non Ingulin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Anaenes diseas 2 X No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di etety filled in 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fun completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 024720 2/18/2009 RAVINDER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD CHEVERLY NIF 31 Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DiPaula, Jr. Vincent 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wiconico 9. Birthplace (State or Foreign Country) 1930 Maryland ional medical Cente 8. Date of Birth (Month, Day, Young 22, Age (In yrs. last birthday) **Funeral** Year) 1**☆** M 2□ F Months Days Hours Director 218-26-3831 78 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show the Middeal Exacilities must be notified at 1 ☐Yes 2X No Director Greenbackville Accomack VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a 23356 USA 3401 Blackbeard Rd. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No permit. Pages 1 and 2 should be filled within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Event. Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entertainment Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Lanzotti ಲ <u>Vincent John DiPaula</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23356 3401 Blackbeard Rd. Greenbackville, VA Barbara J. DiPaula / spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 2/24/2009 4 ☐ Donation /5 ☐ Other (Specify) Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Infaction Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to hinner list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duá to for se a consequence of Examiner The law requires that the death certificate be executed for use es the burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 🔼 No Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Alo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month. Dav. Year) ted cause of death (Item 23a) (Type, Print) 305 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02/21/2009 Rosa M. DeRose 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George 209 Eagle Head Drive Fort Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/25/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F 81 Director 578-74-3769 El Salvador Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Eagle Head Drive 20744 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1⊠Yes 2□No Specify: El Salvador 1 Never Married 2 Married þ Specify: 3 ☐ Widowed 4 🔀 Divorced Year or Dates Hispanic Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celia Campos Juan Antonio Barquero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Silvia Yacob- Daughter 209 Eagle Head Dr., Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State March 2, 09 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 21. Signature of Funeral Service Live see 22. Name and Address of Facility 5755 Castlewellan Dr. Jefferson Funeral Chapel, Alexandria, VA 22315 ienny 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) NON HODGKIN LYMPHOMA **Physician** BYEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 | Inpatient 1 ☐ Yes 2 ☒ No ို 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AKSENTIDEVICH, MD IVAN 32. Registrar's Signature 31. Date-filed (Month, Day, Year)

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title

1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0101234651

ALEXANDRIA

29d. Date signed (Month, Day, Year)

22304

FEBRUARY 22, 2009

Amend #19b, per Inf Black Indelible Ink. Ensure All Copies Are Legible.

December 19 with 19 miles of the miles of th		-	1 - State of Maryland / Department of State of St	artment of Health and Me tificate of Death	ental Hygien Reg. N	ne 2009 0714
## Coulty of Death ## Cou			1. Decedent's Name (First, Middle, Last)	avis	Month Debruary 1	14 2009 11:52 A M
Section Sect	Examin	er	The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Baltimore City If Under 1 Year If Under 24 Hrs. 8	3. Date of Birth	9. Birthplace (State or Foreign Country)
Private Priv	Director		578-70-0317 53 Usual Residence of Decedent	cation	10/14/19	55 Uniontown, PA
Private Priv	the Maryla r 28a-f shor notified at	irector	Maryland Prince George's Capitol H	eights	10g. C	1 X Yes 2 ☐ No Citizen of What Country?
Emerchay/Secondary (9-12) College (1-4 or 5-1) 12	h with		305 69th Street			ited States
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Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Phys	permit. Pag Departmen Important: any injury once.	V 10	21. Signatu, of Funeral Service License	2. Name and Address of FacilityPre	Funeral	Homes, P.A.
Due to (or as a consequence fr):		725	An example of the disease, or complications that saused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dving, such a c dia	re piratoty arrest.	Approximate Interval Between Onset and Death
The search of th	/Medical	1	resulting in death) Due to (or as a condiquence if):	TE TON	•	2
FEMALE: 230. Mas decedent pregnant in the past 12 months? 1 Ves 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 236. Place of Death (Check only one) 241. Was a case referred to medical examiner? 243. Was case referred to medical examiner? 244. Was a case referred to medical examiner? 255. Was case referred to medical examiner? 256. Place of Death (Check only one) 257. Manner of Death Natural Na	be executed sician and burial-transit		Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Thra crania Due to (or as a consequence of):			Zdays 10yews
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25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 2 2 2 2 2 2 2 2 2	The law requered te has been bage 2 shou	Somplete			autopsy performed	24b. Were autopsy findings availab prior to completion of cause of death? No 1 Yes 2 No
Subject to be supposed to the part of the		Be	25. Was case referred to medical examiner?	Other:		6 ☐ Other (Specify)
Thome Solution Property Pr	tending Phy leath. or: After this the funeral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation Suicide 6 Could not be	// AM 1 □ Yes 2 No	Suh	nect fell
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 2	spital or At hours after of neral Direct y filled in by		I 29a Certifier 1 X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	Api Ca L Htc	e(s) and manner as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 2	To the Ho within 24 To the Fu completel	Medic	one) and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
	,		30. Name and address of person who completed cause of death (Item 23a) (Typi		7 7	117/2009
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar FFR 2 3 2009		ato	31. Date filed (Month, Day, Year) 32. Registrar's Signature	600 N	lorth Wolfe	St, Baltimore, MD, 2128

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1035A **Physician** -E3 /Medical 4a. Facility Name (If not institution, give, street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSPI AUTIMOR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours West Indies 59 580-12-2297 **Director** Dec. 19, 1949 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Christiansted 1 ☐ Yes 2 No Director Virgin İslands 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 29 Lowry Hill 00823 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Black <u>۾</u> 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Telephone Elementary/Secondary (0-12) College (1-4or 5+) Lineman Communication 12 7 is marked other traumatic event, If 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maturine Pitre Jacob Darroux ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0082319a. Informant's Name/Relationship (Type. Print) nt of Health a :: If item 27 is r or other tra 29Lowry Hill, Christiansted, Virgin Islands Elixer Darroux 20b. Place of Disposition (Name of cemetery, crematory or other place) | 20c. Location - City or Town, State |Kingshill, St. Croix, 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kingshill Cemetery 3-4-09 4 ☐ Donation 5 ☐ Other (Specify) **Virgin Island** 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licenses Michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 20515 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificata be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contillouting to death but not respliting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

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PLACE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#30perDVR, G889, 3/5/09, WS
State of Maryland Depty 100 Health and Mental Hygiene (1) (1) 9

Certificate of Death

Reg. No. 1 - For State Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Garnet Mae Detrow 11:55P M February 25, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Coffman Nursing Home Hagerstown 8. Date of Birth (Month, Day, Year)
Feb. 24, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1□M 2√ F Yrs Director 219-05-2061 91 1918 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show r than "natural", or iteme 23a or 28e-f show the Medical Exarcher must be rigitled at 1 ☐ Yes 2 ☐ No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 16923 Shinham Road death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ White 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Caregiver Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fitteent of Health and Mental H tent: If Item 27 Is marked other Be Henry McMillian Rebecca Darr 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16923 Shinham Rd. Hagerstown, Maryland 21740 (Daughter) Rosa M. Sours other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) March ö permit. Page Department of Importent: If any injury or once. Hagerstown, Maryland Cedar Lawn Memorial 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 JAU15 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) · a rete /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š ate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, p. Be 25. Was case relerred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Aatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 052323 62-26-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Waseem 1126 Opal Court Hagerstown, Md 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** :00 PM February 2009 Ronald K. Erbe, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8, Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 79 Director 220-24-7679 Nov. 21,1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting of all 1 ☐ Yes 2 X No Anne Arundel Arnold Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 329 Stevens Avenue 21012 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1051 14. Race - American Indian, 11. Marital Status 1 XYes 2 No 1951− If Yes, Give Year or Dates: 1959 Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No White Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Splicer Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Erbe Hazel Sank ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia A. Erbe/ Wife 329 Stevens Avenue Arnold, MD 21012 permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once. Feb. 20 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🌠 Burial 2 ☐ Cremation 3 🖂 Removal from State Cedar Hill Cemetery 2009 4 Donation 5 ☐ Other (Specify) Brooklyn, Maryland Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician espira tory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by tension, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2/No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ### Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

spital or Attending Physician: The law requires that the death certificate be executed tours after death.

•eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records, Hospital e Funeral I

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Medical within 2 To the I

address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis, MD 21401 TEVEN onth, Day, 31. Date filed (Month

29b. Signature and title of certifie

HAMLETTE, MID Registrar's Signature

and manner stated.

park

D0060225

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 9 02 2009 DAVIC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore GP. Maryland Baltimore Medical Center University If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1)X M 2□ F Director 174-38-3140 58 0/16/1950 Lancaster, PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Mcdical Event and be notified at 1 XYes 2 □ No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or: 5539 Green Mountain Circle 21044 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black White etc. 1 □Yes 2√ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2√ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Software Engineer Aircraft Training 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul S. Erb Katharine M. Boeninger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important; If item 27 Is any Injury or other trauonce. DonaldErb (brother) 505 Freedom Circle, Harleysville, PA 19438 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverview Burial Park 2/16/2009 | Lancaster, PA 22. Name and Address of Facility of Funeral Service Licens Fred F. Groff, Inc. comme. 234 W. Orange St., Lancaster, PA 17603 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Box 68760. attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Day 5 Other (specify) P.0. cate has been signed by the page 2 should be detached? 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2√No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

lared

31. Date filed (Month, Day, Year)

University of Maryland Medical Center

32. Registrar's Signature

			State of Maryland / Dep			
			Registrar	rtificate of Death	_	No2009 07146
П	Physicia	an	1. Decedent's Name (First, Middle, Last) Charles Richard Estep, Jr.		2. Date of Death Month February	Day 25, 2009 3. Time of Death 5:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
1	LAdillill	G1	St. Mary's Hospital	Leonardi	own	St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country)
	Director		217-36-6857		May 30, 1	1941 Maryland
	land ow		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	a-f sh	ctor	Maryland St. Mary's	Lexington Pa	ark	1 □Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a	Funeral	21895 Pegg Road Apt.308	20653	Day of the Van and Na	USA
10	ter de	Fun	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
93	urs at al", or Even	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black
2-0	72 ho 'natur dical	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of wo		o. Kind of Business/Industry
121	vithin ene. than	dm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Plumber	1	Plumbing Company
d 2	Id be filed within 72 hours after death with the Maryland lental Hygiene. Hygiene. Red other than "natural", or items 23a or 28a-f show ked other than "natural", or items 23a or 28a-f show to event, the Medical Erena and the national at	ပိ	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	den Surname)
<u>a</u> n	ild be fental rked c	To Be	Charles Richard Estep, Sr.	Ri	uth Johnson	n
Maryland 21215-0036	shou and M is mai			ing Address (Street and Number or F		
Σ 	and 2 lealth m 27 i					ton Park, MD 20653
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if the Zi and Mental Hygiene. In inactual, or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and by no titles at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place) Marc	n 2, 2009	c. Location - City or Town, State
<u>=</u>	nit. Pa artmel ortant injury			Heart of Mary Cemetery 2. Name and Address of Facility		ington Park, Maryland
Ba	Depart Impo		Michael Standine	Mattingley-Gardiner P.O. Box 270 Leonard	Funeral Home	P.A.
			23a. Part . Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line.			
-	Physician		Immediate Cause (Final disease or condition	with shock		Onset and Death
. 1	/Medical Examiner		resulting in death) Due to or as consequence of:	Lung Conce	/	
	Exammer	ē	Sequentially list conditions,	Cory Carre		
	nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ć,	exect an and rial-tra	Examine	resulting in death) Last c. Due to (or as a consequence of):			
8760,	icate be executed physician and the burial-transit	dical	d			
39	ertifica ling ph e as th	Med	IF FEMALE:			
. Box	eath certific attending p for use as	Physician/Me	In the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			
٠ <u>,</u>	w requires that the di been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ž	equire en sig	edb			1 ☑ Yes	2 No 3 Probably 4 Unknown
မင	e law re has be je 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>س</u>	Physician: The la r this certificate had ral director, page 2	S			performed 1 □ Yes 2 🔽	death?
Zi Ki	sician certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	ath (Check only one)	
ō	Attending Physician: The law requires that the death certificate in death, and death certificate has been signed by the attending ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	<u>د</u>	27. Manner of Death 28a. Date of Injury 28b. Time	TIL 3 DOA 4 Nursing	Home 5 ☐ Residence 28d. Describe how i	e 6 Other (Specify)
ion	nding Ph ath. r: After th e funeral	ation	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □Yes 2 □ No		. ,
Division of Vital Records,	r Atte ter dea recto	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	urs aft ral Di					
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or in the basis of examination and or in the	th occurred at the time, date and place nvestigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	ro the vithin Fo the comple	Me	29b. Signature and title of codifier	29c. License number	29d.	Date signed (Month Pay, Year)
			b con	D46374		1/25/2009
	0		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 100010 d Va	NU MI)
	12 ,		23 300 PD/W COROW KT	Con anci for	Antho	ny D. Thomas, M.D., P.C.
	Sta Registr		31. Date filed (Month, Day, Year) September 1997 2009 32. Registrar's Signature	park		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 3:00 a.m. Ronald Α. Evans February 24. 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Piney Point St. Mary's 17846 Clarke Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1xf3xM 2□ F 1943 65 July 17, Maryland 220-40-6093 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐Yes 2X No St. Mary's Piney Point Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20674 USA 17846 Clarke Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Seafood Restaurant 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. Evans Agnes Russell Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Box 140, Piney Point, Maryland 20674 Carol J. Evans/Wife P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. George's Catholic 2/28/2009 Valley Lee, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Laward N. Brinsfield, ₩00052 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 120 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Examiner physician and s the burial-trang Physician/Medical þ Completed certificate Be Certification: To this After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 2 No 1 ☐Yes 2 No 1 Nes 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1, Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd M.D. 25365 Point Lookout Road, Leonardtown, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month David Charles Enty February 21,2009 1:05A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10009 Westerly Lane Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 4/12/1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday Months Days Hours 1 X M 2 □ F 79 Pennsylvania 347-20-1988 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 □ No Alleghenv Pittsburgh 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15218 USA 124 Lacrosse St. Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Port Authority 2 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adale Carter Edward Enty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10009 Westerly Lane Fort Washington, MD. 20744 Lisa Delissio/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Homewood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State Homewood, PA. 2/22/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Licensee alas 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No 4 Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show

"natural"

th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical

Health a

Item 27 other t

Department of Important: If It any injury or o oonce.

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death with

1 and 2 should be filed within 72 hours after

Pages 1 jo

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-trar attending physician for use as the buria been signed by the should be detached funeral director,

Exami Physician/Medical ੬ Be Completed Certification: To

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ficate has I After this s after decade all Director: After the fi filled in by 24 hours a Funeral I within 24 ho

To the Fune

completely f

Medical

State

29b. Signature and title of certifier

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alikhani, M.D. 101 Centennial St. Suite B La Plata, MD. 20646

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

31. Date filed (Month, Day, Year) FEB 2 3 2009

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐Could not be

1 Yes 2 No

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Date of Injury (Month, Day, Year)

and manner stated.

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of Ma	aryland /	-	rtment of H <i>tificate of L</i>				giene Reg. No.	2009	9 07149
Physicia		1. Decedent's Nam	e (First, Middle, La	st)						Date of De Month		Year	3. Time of Death
/Medica		HARO		ELLIFRIT	Z	1	# 03 T	1	- (D 4)-	Month 02	2°7	0 g ar	
Examine	er		addock Ca	re street and number) Ampus			4b. City, Town, or Cumber		or Death			County of Dea	
Funeral		5. Social Security N		Sex 7. Ag	e (In yrs. last b		If Under 1 Year Months Days	If Under	r 24 Hrs.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bi	rthplace (State or Foreign
Director		579-40-9 Usual Residence o	962	ILAIM 2LIF	78	Yrs.				Nov. 1		30 Ne	w Creek, WV
yland now		10a. State	10b. County		10c. City, To	wn or Loc	ation	-					10d. Inside City Limits
e Mar	Director	WV	Minera	a1		New	Creek						1 □Yes 2 No
with th		10e. Street and Nu					10f. Zip Code				10g. Citiz	zen of What C	ountry?
ns 23	Funeral	HC 11. Marital Status	75, Box 4	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H Yes, specity Cuba	6743 ispanic O	rigin? (Spe	ecify Yes or No	D- 1	USA 14. Race - Am	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be mutibed at			ried 2 🔀 Married	Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give	No		Yes, specity Cuba ☐Yes 2♥No	in, Mexica Specify		Rican, etc.)		Black, Whi	te, etc.
ural",	od b	3 Widowed		Year or Dates:	Korean Conflic	:t	ent's Usual Occup						hite
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and 2 salth are 27 is				ritz/Wife		НС	74, Box	41	New	Creek.	WV	26743	
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permi Depar Impor any ir		21. Signature of Fi	uneral Service Lice	Disee SHA		22	Rt. 2.		Sin	ith Fur			6710
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or Atter fter de irecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □Could not to determined	28e. Place of Inj	ury - At home, c. <i>(Specify)</i>	farm, str	eet, factory, office				(Street and wn, State		Rural Route Number,
spital ours a ours a neral C		29a. Certifier	1 ertifying P	hysician: To the best	of my knowled	ige, deati	n occurred at the ti	me, date a	and place,	and due to the	e cause(s)	and manner	as stated.
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)		miner: On the basis of and manner st	of examination								
Voithi Com	M	29b. Signature and	d title of certifier		1		29c. Licens			_	29d. Dat	e signed (Mai	nth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Pau1 Ebersole Herman 9:18 P.M 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mennonite Fellowship Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov . 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 90 Penna. 213-24-8920 1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importants if them 27 is marked oth than "instural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or ther traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD. Director Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12349 Huyett Lane 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give C Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpentry Furniture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ammon Ebersole Amanda Horst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3962 Wintersville Rd. Myerstown, Pa. 17067 J. Mark Ebersole/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Hartleton Mennonite Millmont, PA. 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 22. Name and Address of Facility Zimmerman And Son Funeral Home 45 S. Carlisle St. Greencastle, Pa. 17225 21. Signature of Funeral Service Licensee . Marte 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.

Registrar DHMH 17 Rev 1/2001

Dr

State

29a. Certifier (Check only one)

29b. Signatur

Hagerstown

32. Registrar's Signature

Karras

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northern

MAROS

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

mn

29c. License number

SHAHED MAHMOOD

29d. Date signed (Month, Day, Year)

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		State Registrar 1. Decedent's Name	/First Middle 1	not		Cei	Tillicate of	Deam		2. Date of De	Reg. No.		0 2	3. Time of	
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Funeral		FREDERT C 5. Social Security Nur	mber 6.	Sex HO	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th			nlace (State	or Foreign
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ems	Funeral	11. Marital Status		12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	-		e - Americ	an Indian,	
or it	by Fi	1 Never Married		If Yes, Giv	ve		1 □Yes 2 □ No					Specify		White	
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permit. Pages 1 and 2 should be fried within 72 hours after death with the Maryland geartment of Health and Mental Hydiene. Important: if time Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it with cital Evan in met by netting a once.		20a. Method of Dispo		/ Granda			osition (Name of	ŀ		Date				wn, State	
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2 with 20	2	29b. Signature and ti	tle of certifier					nse number			29d. Dat	te signed	(Month,	Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 145 CM **Physician** 2009 nams9-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 912 MONROE MANOR ROAD STEVENSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In vrs. last birthday) 6 Sex **Funeral** Months Days Hours Min 1 □ M 2 X 70 Yrs. JULY 24, 1938 **NEW YORK** 077-30-0146 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Experience must be notified at SOUTH 1XYes 2 □ No Directo DARLINGTON DARLINGTON CAROLINA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 918 PEARL STREET 29532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, if a Medical Examination. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2**X** No Specify. WHITE Specify: þ 3 ☐ Widowed 4 XDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 DIETITIAN HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE BINGER STELLA BROWN ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 912 MONROE MANOR ROAD, STEVENSVILLE, MARYLAND 21666 SHEILA STAIRS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State FEBRUARY 21 CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A., 106 SHAMROCK ROAD, CHESTER MARYLAND 21619 21. Signature of Funeral Wice Licensee Approximate Interval Between Onset and Death ease or complications the. List only one cause 23a. Part 1. Enter the dis shock, or heart failt at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final NRUS **Physician** ANCIENTE LANCE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the buriat-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐No P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 2 No 2 🗆 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Pother} \) (Specify) RESTDENCE 1∐Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide filled in To the Hospital within 24 hours a To the Funeral C 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certified 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 900 Jasva ck Registrar's Signature 31. Date filed (Month, Day, Year State Registrar FEB 2 a 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 8, 1929 9. Birthplace (State or Foreign Country) 1 □ M 2 □ X F 80 Days 212-26-8339 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 🏚 □ No Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1593 Homeland Drive 3B 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 🎇 No If Yes. Give Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Counter Clerk Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Chambers, Sr. Marie Baumgartner

20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 Lancelot Cross Ellicott City, MD 21042

Crestlawn Mausoleum Feb 24,2009 Marriottsville, MD

HATCHI FUNERAL HOME & CHAPEL? PA

PO Box 195 Sykesville, MD 21784

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

29d. Date signed (Month, Day, Year) 2118/09

Raven BINJ, Ralf. MD 21238

Year

Physician /Medical

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

10a. State

MD

19a. Informant's Name/Relationship (Type. Print)

Mr. Kevin Frank (Son)

21. Signature of Funeral Service Licenses

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\Other (Specify\Entombment

20a. Method of Disposition

Funeral

Director

28a-f show

Director

Funeral

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ed other than "natural", or items 23a or 28a-f show event, the Medical Eventiner must be notified at

Item 27 is marke other traumatic

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or

Baltimore, Maryland 21215-0036

Examiner

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): DSIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or is a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an After this certificate has I funeral director, page 2 s autopsy perform 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

1100764

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

> State Registrar

31. Date filed (Month, Day, Year)

MISG

29b. Signature and title of certifier

560 gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NJL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			Certificate of Death	R	g. No.		1104
	Physic /Medi		1. Decedent's Name (First, Middle, Last) FRM, NG	2. Date of Deat Month	Dey/7	Vana -	ime of Death
A. A	Examir		4e Fecility Name (I not institution, give street and number) HARTLE J HAII NULSING HOME LOCOMO	Re Min	4c. County	este	K
	Funeral Director		5. Sociel Security Number 6. Sex 1 M 2 N F 7. Age (in yrs last birthday) Yrs. H Under 1 Year It Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Worth, Day.	×9929	9. Birthplace (Country)	State or Foreign
	e Merylenc Sa-f show zriffed at	ctor	10a. State ACCOMACK GREENBACKVI'lle			1.0	side City Limits □ Yes 2 No
	eth with th	Funeral Director	1502 DAY FRONT ST. 101. Zip Code 2335	6	og. Citizen of V	SH	
0020	within 72 hours efter death with the Meryland ene. than "naturel", or items 23s or 28e-f show he Medical Examiner must be notified at		11. Marital Sfatus 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes, Give A Year or Dates:	pecify Yes or No- p Rican, etc.)		e - American Inc k, White, etc.	te
Maryland 21215-0020		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ollege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	AV	siness/Industry	
ryland		To Be C	Nelson Collins MARY	ne (First, Middle, A	laiden Sumam	RNe	
	1 end 2 Health e em 27 is ther tra		19a. Informant's Name/Relationship (Type, Print) OR VILLE FLEMING SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Nback	Oc. Location	City or Town, S	1335a
Baltimore,	parmit. Pegas Depertment of I Important: If Its any Injury or o		1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee	422/09 C	ACCNU	gckvi i	1/e VA
	40200		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	VA 23	oximate
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. ALZHEIMER'S DEMENT! Due to (or es a consequence of):			Inten Onse	/al Between et and Death
-	sæcuted n end el-trensit	edical Examiner	Sequentially list conditions, if easy, leading to immediate cause. Enter Underlying				
x 68760,	law requires that the death cartificate be executed as been signed by the attending physician end a 2 should be detached for use as the buriel-trensit	5	Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of):			1	
. Box	daath c	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did to	acco use cor	tribute to the c	auce of death?
, P.O.	that the ned by the detache	y Phys	Tatti. Ottor argumean continuous community to coam out not resonant in the chicking in the chicking is cause great in the art.	1 🗆 Ye			4 ☐ Unknown
Division of Vital Records,	iaw requires that the daath car as been signed by the attandir 2 should be detached for use	Completed by		24a. Wes ar perform		24b. Were au available completi of death?	prior to on of cause
a B	n: The icate h r, page	Co		↑UYa		1 ☐ Yes	2□ No
<u> </u>	ysiciar s certif diracto	To Be	examiner?	th <i>(Check only one</i>		er (Specify)	
0	rng Phy Utter th		27. Menner of Death 1 ☑ Naturel 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury Work? 28c. Injury at Work?	28d. Describe ho			
Divisio	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined etermined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town		er or Rural Rout	e Number,
	Hospit 24 hour Funera itely fills	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred and manner stated.	and due to the ca	use(s) and ma te and place, a	nner as stated. and due to the c	ause(s)
	To the Within : To the	Mec	29b. Signeture and title of certifier 29c. License number	29	_	I (Month, Day, Y	
	1/211		D0062172		2-20	0-200	9
	11/2		30. Name end address of person who completed cause of death (Item 23a) (Type, Print) SHARAD & SATYAL, M.D. 1604 MARKET ST. Police	OMOKE			851
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 0 2009 32. Refistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Month **Physician** 2009 1:25 P Iola Frazier February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40770 Avenmar Court St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year)
Aug. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Hours 83 1925 Tennessee 415-38-9794 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Even front has be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Leonardtown 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code ö 23a 40770 Avenmar Court 20650 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 1 No Specify Specify: 2 3 ₩ Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Scruggs Rankin Reynolds Lucy ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Karen Frazier-Kline/Daughter 40770 Avenmar Court, Leonardtown, MD 20650 other t If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 28/09 Brinsfield-Echols Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service London 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DENENTIA ALZHEIMERS Immediate Cause (Final ADVANCED **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760. physician Physician/Medical the. use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ų in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 10 certificate has 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director; After this certifica director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MY D18096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAM ASJOCIATES MOLLYWOODS GIL A. 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Feb 2009 0945 Sheila Lois Franklin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 🕏 F Hours 25 Washington, Director 577-66-5712 61 0ct 1947 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the World Examiner must be notified at once. 1 ☐ Yes 2 X No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3506 Pear Tree Ct. #34 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) University of the Library Technician District of Columbia vrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Abraham Cousar Maggie Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Franklin - Husband 3506 Pear Tree Ct. #34 Silver Spring, MD. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Riverdale Pk Crematory 2-17-2009 Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Funeral Home 4804 Georgia ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O.1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 \$\text{\$\text{\$Unknown}\$} 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2**X** No 2 🛭 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2∑XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural eral Director: A filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10 D0068150 Feb. 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Nejib Siraj Silver Spring, Md. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **FEB 19** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year orraine trederick Februar A M 8:25 5000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 1, 1930 9. Birthplace (State or Foreign 579-36-3504 Months Days Hours Min 1 □ M 2 🔀 F 78 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3707 Dulwick Drive 20906 TISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 No þ Specify: Specify: White 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Document Specialist U.S. Postal Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Christopher Johnson Wilhelmina Detman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Louise Seek/Daughter 101 Williamsburg Drive, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 23, No Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W. Silver Spring, MD 20901 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic na Vac Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death Day Year 2 X No 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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after death

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Physician:

Hospital or Attending

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Physician

/Medical

Examiner

Funeral

Director

show

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ral", or items 23a or Examiner must be

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than

s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th

Pages

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Page Department o Important: If any Injury or

the Medical

or other If Item

Director

Funeral

Be

2

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner burial-transit Physician/Medical the for use detached Be Completed by page 2 should director, Certification: To funeral

1 ☐ Inpatient

24a. Was an perform 1□ Yes 2 1No

28d. Describe how injury occurred

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No 1 Tes 27. Manner of Death 1 Natural 5 Pending 2 Accident

NOW,

3 Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Tes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0053337

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 200 Reinterstown

State Registrar

Dear 31. Date filed (Month, Day, Year) 19 FEB



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** William Frost James /Medical 09 0512 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND WMHS-BRADDOCK CAMPUS ALLEGANY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 14, 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min 219-46-0273 Director MD 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Movical Examinat must be notified at MD Allegany Cresaptown Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13700 Craddock Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a nand Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ N Specify: Yes, Give \$ 3 Widowed 4 Divorced Year or Dates: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sheriff's dept deputy sheriff 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cecil Frost Lola Mae Buskirk Frost ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau wife 13700 Craddock Road Bonnie Frost MD 21502 Cresaptown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ **S**urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1 ☐ Burial 2 ☐ Cremation 3/4/2009 Rocky Gap Veteran's Cemetery MD Cumberland 21. Signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute MESENTERIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dualto (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 Box 68760. attending physician for use as the buria Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. the signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been si RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Division of Vital 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death Aftert 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 [Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

To the Hospital or Attending Physician: To the moor after death.

To the Funeral Director: Af

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Srive Cumberland, MD

AJAYI, M.D

29c. License number

D0066606

29d. Date signed (Month, Day, Year)

02

09

State Registrar

one) 29b. Signature and

OLAIDE

			1 - State Registrar	State of Maryla	nd / Depa	artment of Hertificate of E	ealth and I Death	Mental Hy	rgiene (09 0715	9
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	3. Time of Dea	ath
	Physici /Medio		Richard Daniel	Grimm				Feb.	19, Day 200	10:08a	ı M
ř	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat		4c. County		
			Long View Nursi	ng Home		Manch	ester			Carroll	
	Funeral		Social Security Number 6. Sex	3 , ,	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	Birthplace (State or Fo Country)	oreign
	Director		215-32-2309	M 2 F	1.6 Yrs.	misining Suyo	110010	July		MD.	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ecation				10d. Inside City Li	imite
	Aaryli sho	٥	MD Baltimore			erco				1 Tyes 2	
	28a-	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of V		
	Sa or	Funeral Director	3326 Mt. Carmel Ro	ad		21155			rog. Onizon or t	USA	
	death me 2;	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent of His	panic Origin? (S	pecify Yes or No	D- 14. Rac	e - American Indian,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other Z is marked other than "naturel", or iteme 23s or 28s-f show other treumatic event, the Medical Examinal minist be rediffed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		lf Yes, specify Cuban 1 □ Yes 2 🙀 No	, Mexican, Puert Specify:	o Rican, etc.)	Blac	ck, White, etc. v: white	
ŏ	2 hou	Completed	15. Decedent's Educ			dent's Usual Occupat			16b. Kind of B	usiness/Industry	
215	Pin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	iring most of woi	rking			
2	od wit	No.	6		fact	ory worke	r		tool	company	
힏	al Hy l oth	Bec	17. Father's Name (First, Middle, Last)						, Maiden Suman	n <i>e</i>)	
Maryland	Menti Menti arked	To	George D. Grimm					lizabeth			
a	12 sh and reum	10 2	19a. Informant's Name/Relationship (Typ		1	ng Address (Street ar					
e)	1 and tealth		Linda M. Naylor, d			Poole Rd.	, westmi	nster,			
Baltimore,	Pages nent of I int: If It		1 □ Spurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crer	dge Cemete	'			City or Town, State	
	무운원들 .		21. Signature of Funeral Servicer/License		TESU KI	. Name and Address	of Facility 703	5/2009	opperco,	, Ma.	_
ñ	Depa Impo eny to) J	Thanda L'Le	nmer	9	34 S. Mai	n St F	ine run Bampstea	eral Hon	ne 21074	
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	ations that caused the dea						Approximate Interval Between	n
	Physician		Immediate Cause (Final disease or condition	Carlana	n O.	acce	lint			Onset and Death	
•	/Medical Examiner		resulting in death)	Due to (or as a conse			<i>y</i> / <i>y</i>				
Н	Examine	er	Sequentially list conditions, b	On the Control of							
	nsit		cause. Enter Underlying Cause (Disease or injury	Due to (or as a sonse	quanca ory.						
_,	cate be executed physicien and : the burial-transit	Examin	that initiated events cresulting in death) Last	Due to (or as a conse	quence of);						
8/60,	e be /sicier	dical									
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gox	death certifi e attending id for use as	2	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pregr 1 Live birth 2 Fel		35-4			23d. Dat	te of delivery	
	0 0 0	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Ectopic pregnancy Other (specify)			Mo	nth Day Year	
r Ö	at the de by the	hy	9 ☐ Unknown								
Š,	law requires that the es been signed by th 2 should be detache	þ	Part II. Other significant conditions con	ributing to death but not re	sulting in the u	nderlying cause giver	in Part I.	L.		ribute to the cause of death	
0	w requir been si should	Completed		·				123	Yes 2□No	3 ☐ Probably 4 ☐Unkn	оwп
Hecord	e law hesb je 2 st	ple						24a. Was	an 24b.	Were autopsy findings avail prior to completion of cause	able
_	Page 1	် ပ							ormed?	death? □ Yes 2□ No	
Vital	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?				26. Place of Dea	th Check only	one		
5	> .2 0	၉	10165 22110	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Other	4 Nursing H	ome 5 ☐ Resi	dence 6 □Oth	er (Specify)	
		ë.	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe	how injury occurr	red	
<u> </u>	Attending r death. actor: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2□No				
=		ertification;	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural Route Number,	
_	Hospital or 24 hours afte Funeral Dir etely filled in	O	29a. Certifier 1 Certifying Phys	cien: To the best of my kn	owledge, death	occurred at the time	, date and place	and due to the	cause(s) and ma	nner as stated.	
	he Ho in 24 i he Fu pletek	edical	(Check only 2 Madical Examin	er: On the basis of examinand manner stated.	ation and/or inv	estigation, in my opin	nion, death occu	rred at the time,	date and place, a	and due to the cause(s)	
	To the complex	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, Day, Year)	
	- K		KJohn W m	delleton n	NA	Print)	2443		2/19/	2069	
1	3		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type,	Print)		, ,	-01m		
	`	-	John W. Middle	tin 3337	Victo	My Stream	4. Man	cheste	MU:	21102	
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Sign					1		

			1 - For State Registrar	State of Marylar	id / Dep $C\epsilon$	artment of hertificate of	lealth and M <i>Death</i>		iene 2 () eg. No.	109	07160
	Dhyoisi		1. Decedent's Name (First, Middle, Las	1)				Date of Deat Month		Year	3. Time of Death
and the last	Physici /Medio		Charles Goytia					Februar	y 21, 2	2009	ვ:23 P ^м
	Examin	ner	4a. Facility Name (If not institution, given 2909 Vulcan Road	street and number)			r Location of Death		4c. County		
-epol ^o	Funeral		5. Social Security Number 6. Se		last birthday	Dundalk H Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltim		place (State or Foreign
	Director		099-20-6607] M 2□F 8	1 Yrs.	Months Days	Hours Min.	Nov 20.			to Rico
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	NY	Bro	nv						1∭Yes 2 No
	or 28	Director	10e. Street and Number	DIO	IIV	10f. Zip Code		1	0g. Citizen of W	√hat Coun	itry?
	s 23a		665 Thwaites Place			10467			SA		
	ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 □Yes 27□No	S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White, e	can Indian, etc.
5-0036	i within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medicel Exeminar must be ricitlied at	þ	3 ☐ Widowed 4 ☒Divorced	1 Yes 2 No If Yes, Give Year <i>o</i> r Dates:		1 XYes 2 No	Specify:	cto Rica	Specify	Whi	te
2	72 hc	etec	15. Decedent's Ed (Specify only highest grad	lication le completed)	16a. Dece	edent's Usual Occup			16b. Kind of Bu		
7	filed within Hygiene. wher than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sales		d)		Retail	Co10.	
and 7	al Hyg other	Be C	17. Father's Name (First, Middle, Last)		Darce	TIKAL 1	18. Mother's Name				5
ylar	2 should be filed w h and Mental Hygie r is marked other t raumatic event, In	To E	Venancio Goytia				Isaias Mo	rales			
Mar	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 is marked othe or other traumatic event,	1 3	19a. Informant's Name/Relationship (7	vpe. Print)	1		and Number or Rura		City or Town,	State, Zip	Code)
a,	ss 1 and of Health item 27 rother tr		Armand Goytia/son 20a. Method of Disposition	20b. F	2909 Place of Disp	Vulcan Rousition (Name of	ad Dundal		1222 20c. Location -	City or To	wn State
Ē	Pages nent of I ant: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cre	matory or other plac	ory 02/24		Odenton	•	,
банттог	permit. Page Department (Important: If any Injury or once.		21. Signature of Funeral Service Licent				ss of Facility Crematic	-			-
<u>n</u>	89 5 2		Devely & Ha	elitte MOI	251 E	Severly L.	Heckrott	e PA	Clarks		MD 21029
		0. 0	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.		ter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	1	Approximate Interval Between Onset and Death
The same	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	cer						2 months
	Examiner			Due to the as a conseq	uence ot):						
	p .ts	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that safetad as	Due to (or as a consequent	uence of):						
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	ioneo of):						
00/00	ficate be executed physician and s the burial-transit	is E		Due to (or as a consequ	derice oi).						
00	tificate ng phy as the	edical		J						;	
Š	leath certifi attending for use as	an/In	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	v			e of delive	*
5	he dez the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of c 9 ☐ Unknown		Other (specify)			Mor	ntn	Day Year
r.	that the position of the posit		Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contri	ibute to th	e cause of death?
ecords,	en sig	ed by						1 □ Ye	s 2 No	3□ Prob	ably 4 ☐ Unknown
2	law re nas be	Completed						24a. Was an	24b. W	Vere autor	psy findings available inpletion of cause of
<u> </u>	r: The icate h	Con					to the same of the	perform 1 □ Yes 2	No 1	eath?	
N II G	sician certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		other actions of the	26. Place of Death				Sons
5	g Phy erthis erald	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	III 3 LI DOA	4 ☐ Nursing Hor	me 5 Reside			nome -
2	endin sath. or: Afi he fur	atio	1 Anatural 5 Pending investigation	(Month, Day, Year)	Injury		Yes 2 □No				
2	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, st	reet, factory, office	2	28f. Location (Str City or Town,		er or Rural	Route Number,
-	spital lours a neral I		29a. Certifier Certifying Phy	sician: To the best of my kno	wledge, dear	h occurred at the tir	ne, date and place a	and due to the ca	ause(s) and ma	nner as si	tated
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after decarth. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Exam	ner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my o	pinion, death occurre	ed at the time, da	ate and place, a	nd due to	the cause(s)
	With With Co.	Ž	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed	(Month, E	Jay, Year)
	3		Michelle M. B	dor CRNY		RII	02370	F	ebnany	23 1	2009
	EG.		30. Name and address of person who co Michelle M. Beddy C	empleted cause of death (Item		Print)	cene St, S	gille D	a Chimira	000	21201
	Sta	te	31. Date filed (Month, Day Year)	32. Fegistrar's Signar	ture	1 23.01	core of 1	July D	MININE	IVIU	
	Registra	ar	ILDETA	100 Knews	1. 19	aver					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HILDA VICGINIA GRAVES
4a. Facility Name (If not institution, give street and number) GrAVES 2 20 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestentown
If Under 1 Year If Under 24 Hrs. CHESTER RIVER HOSPITAL CENTER 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F \$2 Yrs. 20.16.9987 Director mo april 16 1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23e or 28e-1 show 10c. City, Town or Location 7 is marked other than "natural", or Items 23e or 28e-1 show traumatic event, the Mudical Expressor must be notified at 10b. County 10d. Inside City Limits 1 Tes 2 No Director MD Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 21620 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ₩idowed 4 Divorced Dlack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UpTown Club 1/# OWNER/OPERTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL LINDSE. KOSIE LIVELY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other trau lonieA Grave- Daughter 1269 Proudience Knoll Dr. Kichmond 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) JANE United Methodist 2.28. 2009 Chestertown MD Signature of Funeral Service Licensee 22. Name and Address of Facility Kenneth WAILEY FUNERAL SERVICE .Wa (WOOO26) EZI W.ST. Annapelis, Maryland 21401 23. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 day /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 3□ DOA 2 ER/Outpatient Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lue, Chestistown KINK WUN, Washington 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 12:05AM Thelma Reid Genga 02 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisburg Hospice At the Lake Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F Director 218-16-6572 93 June 21, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be notified at Director 1 ☐ Yes 2 X No Wicomico Mardela Springs 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21837 U.S.A. 9931 Sharptown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 133Yes 2 No 1943-If Yes, Give Year or Dates: 1944 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: white 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse <u>Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Millard Reid ပ Kemma Ann Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 9931 Sharptown Road Mardela Springs, MD 21837 John Genga 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02-23-2009 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet. Cem. Hurlock, Maryland 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 East Grove Street Delmar, DE 23a. Part 1. Efter the disease, or communations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NBUMD /Medical Due to (or as a consequence of): Examiner THRIVE AILURR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 profiths? 3 Ectopic pregnancy Month Day 5 Other (specify) P.0. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 si 24a. Was an autopsy The perform 24Ro 1 ☐ Yes 1 🗆 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 Yes 2 XNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Marmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

THE

The ma

State Registrar (Check only

Calfuntu 31. Date filed (Month, Day, Year)

29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

WAM

29d. Date signed (Month, Day, Year)

8410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01425 State of Maryland / Department of Health and Mental Hygiene Keisha Gallman 2009 07163 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day February 18, 2009 GALLMAN 0914 hrs KEISHA Medical Examiner 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Country) Days Hours Min. Months Director 1 M 2 X F MARCH 14 1980 WASHINGTON, DC 216-17-0541 28 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show PRINCE GEORGE'S HYATTSVILLE MD with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 5 20784 USA 3559 55TH AVENUE 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican; Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. ą White etc death 1 Armed Forces? 1 X Never Married 2 Married Yes 2 X No 9 BLACK Yes, Give Yea Yes 2 X No specify: Specify: Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 1 Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' the Medical 12TH ADMINISTRATION ASSISTANT PRIVATE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOUIS N. GALLMAN ALICE DELANEY traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 5439 TAUSSIG ROAD BLADENSBURG, MARYLAND 20710 LOUIS N. GALLMAN/FATHER 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) XBurial 2 Cremation 3 Removal from State 2/25/2009 RESURRECTION CEMETERY CLINTON, MARYLAND Donation 5 Other Specify: njury or 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Enter the disea **Physician** failure. List only one cause on each line. Between Onset and Medical Death Seizure disorder Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,27 per me g890 4-20-09 vt X UNPENDED the attending physician ed for use as the burial Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No the Hospital or Attending Physician: thin 24 hours after death, the Funeral Director: After this certific mpletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number O.C.M.E. February 19, 2009 who completed cause of death (Item 23a) 30. Name and address of person Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 32. Regist Registrar

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			For State		State of Ma	arylan			Health and	Mental Hy	ygiene 2 (109	07164
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20		30. Name and andress of person who	completed cause of death (iter	m 23a) (Type		- LARG	a UD-	2077	4	
Sta	-	31. Date filed (Month, Day Year)	32. Fegistrar's Sign	ature	bores	17/11/00/1	1000		1	
Registr	ar	पंत्रताच्या स्थापि 🐓 🖁	MAN TOWN	7 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per phys. G889 3/9/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 07166 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death 2009 **Physician** CHARLES F. GRIFFIN 2:00 JANUALA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PERRY Point VANARY LAND HEALTH CARE SYSTEM Months Days Hours Min. 8, Date of Birth (Month, Day, Year) 8/29/1923 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 11 M 2□ F Months 216-16-5319 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event is a number notified an once. 1 ☐ Yes 2 No Director Pylesville Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21132 1222 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 MaYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ WWII 3℃Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Norris Nelson Griffin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 564 Jamestown Court H, Edgewood, MD 21040 Glenn Griffin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Air Mem. Gardens: 1/14/2009 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicens 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** ARTERY D MICHOLIA disease or condition resulting in death) /Medical Examiner YPERCHOLEST Gequentially hat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENSTON ESSENTIAL burial-transi Due to (or as a consequence of): Box 68760. e Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.0. detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 RIKINSON icate has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No of Vital funeral director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 → Impattent 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JANUARY 11, 2009 DAYGY8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HASHMI, M.O. VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, NO 21902

State Registrar

DHMH 17 Rev 1/2001

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MAN 2 I 20

32. Regetrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Jerome Hunt, Sr. 10:30 A M February 2009 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 1244 Baliol Lane Odenton Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/11/1963 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 14⊾ M 2 ☐ F Months Days Hours Min. 213-88-3116 45 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1244 Baliol Lane 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Road Paver Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Oliver Hunt, Sr. Rose Marie Curtin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1244 Baliol Lane, Odenton, Maryland 21113 Donna M. Taylor/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify Kalas Crematory 02/21/2009 | Edgewater, Maryland 21. Signature Juneral Servi 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a rt1. Enter re disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or cart failure. List only one cause on each line. Inmediate C use (Final Approximate Interval Between Onset and Death ancer - un Known primary resulting in death) Due to (or as a consequence of) Hepatiti Sequentially list conditions, if any, leading to immediate cause. Enter thickning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any injury or ot

Physician

/Medical

Examiner

Funeral Director

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Medical Examinating the motified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examine a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Purporal Director: After this certificate has been signed by the attending physician and lefely filled in by the furneral director, page 2 should be detached for use as the burial-transit

Physician/Medical 2 Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death

1 ☐Yes 2 ☐ No 9 Unknown

autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sister's 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Residence 28d. Describe how injury occurred 28c. Injury at Work? investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

1 Yes 2 No

5 Pending

FEB 1 9 2009

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 - Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D0063239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 201, Edgewater, Marylnad 21037 Yankey, Rache1 3169 Braverton Street 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

Medical

completely

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Phys	ician
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Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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uneral irector		5. Social Security Number 180-38-3417 Usual Residence of Decedent	6. Sex 1 M 2 F	7. Age (In yrs.	95 Yrs.	Months		Hours Min.	Mar	of Birth onth Day, Ye	913	Kore	place (State or Foreign intry) 2a
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	6		M. A.	you	M	4	D343	85		Februar	y 23,	2009	
	E.G.		30. Name and address of person George S. Groma					Pkur Sui	te 101 (Columbi	a MD	2104/	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature		LINY, DUL	LC LOL (رسد وعب		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:07 A^M 21 2009 Joyce Elizabeth Hoddinott February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1050 Streaker Road Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year 12–26–1937 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ▼ F MĎ 219-26-8146 71 Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10b. County 1 ☐ Yes 200 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 21043 USA 8145 Q Cyprus Cedar Lane Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ██No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) Homemaker Own Home 12 should be filed w h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Rhodes Clara E. Pope ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If item 27 is any injury or other trau Suzanne E. Toomey 1050 Streaker Rd., Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l. Cem. 3-11-2009 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signatu of uneral fer ce Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 Approximate Interval Between Office and Death 23a. Part f. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one one of him. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and Due to (or as a consequent P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

(19a2)

State Registrar

February 23, 2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:48 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University

5. Social Security Number Ba of land timore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 X M 2 □ F 215-42-3729 64 Director 8/28/1944 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Wedical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2X No **Funeral Director** MD Frederick Jefferson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4317 Teen Barnes Rd. 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 SX/es 2 □ No 1966 — If Yes, Give Year or Dates: 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Be Completed by SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) federal Elementary/Secondary (0-12) College (1-4or 5+) government contract specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Moxley Adelaide Hartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Hartman (Wife) 4317 Teen Barnes Rd., Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burra 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery2/20/2009New Market, MD 21. Signature of Funeral Service Lic 22. Dona'ld Grespo Family Flowers Funeral Home POB 18, Middletown, MD 21769 Approximate Interval Between Onset and Death 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** lumor /Medical Due to (or as a consequence of): Examiner Kitts 1mphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 T Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a, Certifier 1🙇 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AU4176435 E18956 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Estess Baltimore, MD harisse S. Greene 33 32. Registrar's Signature State 182820 D Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Horace Darfus Hill February 2009 7:45 a.^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Dorchester Mallard Bay Care Center Cambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min. 298-14-5978 Feb. 14, 88 1921 Geórgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Pacific Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married If Yes, Give Year or Dates: WWII 1 ☐Yes 2 X No Specify: black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) press operator automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Hill Areatha Days 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Hill wife 313 Pacific Ave., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 2/28/09 4 Donation 5 Dother (Specify) Mt. Peace Cemetery Akron, OH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. LJ lemos 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumoria Aspirat ·UN disease or condition resulting in death) Due to (or as a consequence of): Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its leading to the cause). Alzhei M that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

MD

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Accold Examinar mant by notified at

filed within 7 I Hygiene.

1 and 2 should be filed wi Health and Mental Hygier em 27 is marked other th

Health a

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Department of Important: If It any Injury or o

Pages 1

death \

Baltimore, Maryland 21215-0036

sician and burial-transit physician use as the for signed by the a page 2 certificate

The law requires that the death certificate be executed

Box 68760.

P.O.

of Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Physician/Medical Completed by Be Medical Certification: To

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

0 State

5 Pending investigation

6 ☐ Could not be

28b. Time of

29c. License number 23 6

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 23/2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

ic J. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Widmaier, Dorchwer Cumbrida

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

and manner stated.

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARY CROCKER HOGG February 0520 <u>20</u> 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Hospital Talbut Memorial Easton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 X F 266-32-7388 83 DEC. 6, MASSACHUSETTS Director 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 CHESTERFIELD AVE. 21617 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. □Yes 2 Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FOREIGN SERVICE STATE DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK T. HOGG MARY C. DEVEREUX ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK T. HOGG, JR./BROTHER 207 EARLE AVE., **EASTON, MD 21601** Date 24 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of CHESAPEARE ON 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) CENTER STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Mirma K.H 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** es weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner horne if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by suction 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 🗆 No 1 ☐Yes 3 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1)⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation * Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in I 24 hours a Funeral L 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. 14

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2009 4:10 AM FEB. 19, MARTHA HALLIBURTON Η. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL LUTHERAN ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 1, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Davs Min. GEORGIA 84 262-15-9355 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show ROCKVILLE MD. MONTGOMERY 1X Yes 2 □ No Director Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20850 9701-VEIRS DRIVE USA d other than "natural", or items 23a event, the Medical Examiner must be Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: WHITE þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) eathir, wental Hygiene.
127 is marked other than "r traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION YRS 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) BLANCHE DILLARD ROY E . HOWARD ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18707- CAPELLA LANE, GAITHERSBURG, MD. 20877 JANE LEHRMAN- DAUGHTER Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition METROPOLITAN CREMATORY-2/20 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW Signature of Funeral Service Licen HYSONG CO. WASHINGTON.DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1/Car disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Cause (Jesus or injur that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 11No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury n 24 hours after death.

e Funeral Director: Af letely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES W. KARESH- 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFR 2 4 2009 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

PRINC

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

31. Date filed (Month, Day, Year)

Iram Akram Khan, M.D.

FREDERICK

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Maryland of Penalth of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Alfred Mullendore Huffer 4:00 p February 2009 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington

9 Birthplace (State or Foreign Country) 11 Ford Avenue Boonsboro If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Min. Hours 1□M 2□F 220-30-9727 Director Feb 25, 1929 | Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland | Washington Boonsboro the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Funeral 111 Saint Paul Street 21713 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: aE No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Meonce. Elementary/Secondary (0-12) College (1-4or 5+) Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Wilber Alfred Huffer <u> Gladys Irene Mullendore</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19700 Huffer Lane, Boonsboro, Maryland <u>Delbert Huffer - brother</u> 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonshoro Cemetery 2-22. Name and Address of Facility 2-24-2009 Roonshoro, Maryland 21. Signature of Funeral Service Licensee Dasc-Stautier Funeral Home 7606 Old National Pike, Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Bast-Stauffer Funeral Home Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 2□ certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes after death.

Director: After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral Completely filled in Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print)

5H-12 State Registrar

31. Date filed (Month, Day, Year)

Tace

32. Registrar's Signature

FEB 23

MD 21713 William F. Bods

K.K

State Registrar

Hegistrar
DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PINE

KOCKVILLE, MARYLAND

20850

			For State Registrar	State of	Maryland / De	partment of I ertificate of	Health and I Death		ene 1. No. 20	09	071	78
	Physicia	an	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day 17, 2	Year	3. Time of De 1:19A.	eath M
	/Medic		Dolly Johnson 4a. Facility Name (If not institution	give street and num	nher)	4b. City Town, o	r Location of Death	February	4c. County		1:13A.	
	Examin	er	Laurel Regional		·	Laurel	. Ecoudion of Bout	·			orge's	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp	lace (State or F	Foreign
	Director		579-62-6637	1□M 2ÅF	74 Yrs	. World's Days	Hours Will.	10/23/19			MD	
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	0d. Inside City	Limits
,	f sho	ö									1⊠Yes 2	. □ No
	the N	Director	DC 10e. Street and Number		Washing	10f. Zip Code		100	g. Citizen of W	hat Coun	try?	
:	3a or	Ē	3726 Southern	Avenue S	F	2002	20		U.	SA		
	death	Funeral	11. Marital Status			Was Decedent of I If Yes, specify Cub		pecify Yes or No-	14. Race	e - Americ k, White, e		
٥	after or ite		1 ☐ Never Married 2 X Marr		2 📆 No	1 □Yes 2⊠No		o riidani didiy	Specify:			
5-0036	within 72 hours after death with the Marylan ene. than "natural", or items 23a or 28a-f show in itedical Exactions to a radificat	d by	3 Widowed 4 Divorced	Year or Da	ites:			146	Sb. Kind of Bu	DIO		
င်	n 72 h	Completed	15. Deceden (Specify only highes	t grade completed)	(G	ecedent's Usual Occu live kind of work done le. DO NOT use retire	during most of wor.		D. KING OF BU	isiness/inc	iustry	
1717	withi	E O	Elementary/Secondary (0-12)	College (1	-4or 5+)	memaker	,		Own Hor	ne		
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show vent, I'm invelical Evanitum to modified a	Be C	17. Father's Name (First, Middle,	Last)	, , , , , , , , , , , , , , , , , , ,		18. Mother's Nan	ne (First, Middle, Ma	aiden Surnam	e)		
/ <u>la</u>	uld be Menta Irked Irked	To E	Raymond Burch				Mary H	ickman				
Maryland	2 sho and is ma	1	19a. Informant's Name/Relations			ailing Address (Stree						
≥ . თ`	permit. Pages 1 and 2 should be filed v Deportment of thealth and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, II any injury or other traumatic event, II and injury or other event, II and		Michelle Johnson	n-Vailes/					ghts, Noc. Location -			
Baltimore,	iges 1 nt of h if ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		state	sposition (Name of crematory or other pla	i			•		
	it. Pa trime ortant njury		4 ☐ Donation 5 ☐ Other (S	110	Cedar H	Iill 22. Name and Addro			Suitla:			
g	Department of the series of th	v J	21. Signature of Furieral Service		(X)	6500 Aller						
			23a. Par 1. Enter the disease, or	complications that ca	aused the death. Do not	- Committee of the Comm					Approximate Interval Between	een
-	Physician	i i	shôek, or heart failure. List Immediate Cause (Final disease or condition	•	ovolemic Sh	ock				1	Onset and De	ath
	/Medical		resulting in death)		or as a consequence of):							
	Examiner		Sequentially list conditions.		tal Bleedir							
	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury		or as a conse uence of					-		
	execut and al-tran	xan	that initiated events resulting in death) Last		oxic Encept or as a consequence of):	alopatny						
09/8	eath certificate be executed attending physician and for use as the burial-transit	lical		d. Syr	соре							
×	certific	Physician/Mec	IF FEMALE:	23c. If yes, out	come of pregnancy				22d Dat	te of delive	arı/	
Rox	eath atter for u	cian	in the past 12 months?	1 Live b	oirth 2☐ Fetal death mant at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		Mo		Day Ye	ar
)	the	hysi	1 □Yes 2 ☒No 9 □ Unknown	9 ☐ Unkn	own							
	law requires that as been signed b 2 should be deta	by Pl	Part II. Other significant condition		eath but not resulting in th	e underlying cause gi	ven in Part I.	23e. Did toba	acco use contr	ribute to th	ne cause of dea	ath?
ğ	equire en sig		Metabolic Aci	dosis				1 🗆 Yes	2 No	3 ☐ Prob	ably 4 🔼 Un	ıknown
Records,	as as	Completed						24a. Was an autopsy	F	prior to co	psy findings av mpletion of cau	railable use of
_	Th ate pag	Son						perform 1 Tes 2		death? 1 ∐ Ye s	2 🗆 No	
Vital	i lcian: Thi certificate ector, pag	Be	25. Was case referred to medica examiner?	Hospital:		Ot	her	ath (Check only one,			_	
6	Phys r this ral dir	P.	1 Yes 2 No 27. Manner of Death	1 💢	npatient 2 ER/Outport	atient 3 DOA	4 LI Nuising r	lome 5 ☐ Resider 28d. Describe how			y)	
5	Attending Physician: It death. ector: After this certific by the funeral director,	ţion	1 Natural 5 Pendin 2 Accident investi	9	of Injury 28b. Tin th, Day, Year) Inju	ry Wa	rḱ?]Yes 2 □ No		,,			
_	늘 말 들 ㄷ	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod Zoe. Place	of Injury - At home, farm ng, etc. <i>(Specify)</i>	, street, factory, office		28f. Location (Stre City or Town,		er or Rura	i Route Numbe	e <i>r</i> ,
	pita ours eral fille	edical Co		Examiner: On the b	best of my knowledge, of asis of examination and/oner stated.							
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifie		7	29c. Licen	se number	29	d. Date signed	d (Month,	Day, Year)	
	->-0	1	> MA5	NO C	W	> _{D0059}	1649	Fe	bruary	20,	2009	
D	2		30. Name and address of person I. Mbonu, MD,			pe, Print)	WILLIAM TO THE REAL PROPERTY OF THE PERTY OF	MD 21201				
7	Sta	te.	1. MDONU, MD, 31. Date filed (Month, Day, Year)				TUINOTE,	III 21201				
	Regist		FEB 2 4 2009	Denver !	egistrar's Signature							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death y 21, 2009 Physician 10:30 A_M February Mildred Elmena Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 31, Birthplace (State or Foreign
Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 71 Maryland 220-38-0951 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Evantual ruust or notified at 1 ☐ Yes 21 No Director Maryland St. Mary's Hollywood permit. Pages 1 and 2 should be filed within 72 hours after death with the N. Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "nature" any injury or other traumatic entering any injury or other traumatic entering any entering any entering enterin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24575 Mt. Pleasant Road 20636 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2 📉 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Housekeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Margaret Langley Clarence Armsworthy P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24575 Mt. Pleasant Road Samuel Albert Jones / Husband Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland Charles Memorial Gardens 4☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Sennet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
pnset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury Examiner 200 to (or at The law requires that the death certificate be execute physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. the : 1 ☐ Yes 2 ■ No. 9 Unknown signed by to Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 3 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 1 ☐ Yes 2 1 No certificate 1 ☐Yes 2 ☐ No NS or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: After this c funeral dire 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 □ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed ca se of death (Item 73a) (Type, Print) Box 640 Three Notch Rd. Hollywood, MD 20636 James Jarboe, MD P.Ø. Ragistrar's Signature 31. Date filed (Mon State 3 2009 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:32 PM 15, 2009 Feb. Pong Sun Kwon /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Center Washington Fort Washington Medical Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Months 1 □ M 2 🛛 F Feb. 20, 1924 Director Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Fairfax Springfield Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Korea 5269 Leestone Ct. 22151 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Saltimore, Maryland 21215-0036 Specify: Asian Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Kwon Eun Yi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5269 Leestone Ct., Springfield, VA, 22151 Joseph Sim/Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairfax Memorial
Funeral Home Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 Home 2009 Fairfax, Virginia 22. Name and Address of Facility Fairfax Memorial Funeral 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home, 9902 Braddock Rd., Fairfax, VA22032 Bernoulette Danus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10: on ar Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Injury 5 ☐ Pending investigation (Month, Day Year) 1. Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Registrar

State

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

VU

FEB 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11711

LIVINGSTON

32 Registrar's Signature

29a. Certifier

TUKN

Medical

Ri).

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dec 5569

FORT WASHINGTON

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18, 2009 12:15 AM Lewis February Evelyn Opal /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16005 Meandering Drive Brandywine

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Charles 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year. 1 □ M 2 🖬 F 87 Nov. 9. Nebraska Director 493-22-8617 Usual Residence of Decedent within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is used by instifted at 1 ☐ Yes 2 ☑ No Director Brandywine Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20613 16005 Meandering Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No þ Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lula Adams Van Tinnel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57332 19a. Informant's Name/Relationship (Type. Print) 411 North 6th Street P.M.B. 2150, Emery, S.D. Clark Lewis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans' Cemetery: 02/25/2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3035 Old Washington Road Huntt Funeral Home Waldorf, Maryland, 20601 m01190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 000 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Year 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 □ No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Registrar

Manoj Panwala, 37767 Market Dr. Charlotte Hall, Maryland, 20622 31. Date filed (Month, Day, Year) FEB 2 3 2009

29b. Signature and title of ce

30. Name and address of

32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

and manner stated.

parket

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 07183

		For State gistrar		Certif	icate of l	Death		2. Date of D	Reg. No.	40	103	0110.
Physician/ Medical Examiner	1.	Decedent's Name (First, Middle,Last) Stephen Mark	Stephen Mark Lewis acility Name (if not institution, give street and number) 4b. City, Town, or Location of D								0	me of Death 946 hrs
,	48	a. Facility Name (if not institution, give 205 Cedar Street	street and number)		41	Cambridge			1 0	County of Corchester	er	
Funeral Director	2		7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Aug.		1962	9. Birthplac Foreign Country	ME
faryland 28a-f show any 1 at onc. ector	10	sual Residence of Decedent Da. State 10b. County MD Dorches		I 0c. City, To	own or Locatio	Cambrio	dge		Tana Cit	izen of Wha	1 [Inside City Limits X Yes 2 No
the Maryland 3a or 28a-f sh otified at one		De. Street and Number 418 Shepherd Av	venue			216	513		Tog. Oil	U	ISA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	L	The state of the s	If Yes, Give Year or Dates:	No	If Ye	Decedent of Hispa s, specify Cuban, I Yes 2 X No s Usual Occupatio	Mexican, Pue specify:	rto Rican, etc.)		14. Race - White, Specify: Kind of Bus		
5-0036 ed within 72 hours lygiene. other than "natu the Medical Exan Completed	-	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or 5			st of working life. I laborer			-		rina	"
215-00 be filed with antal Hygiene riked other i ent, the Me		7. Father's Name (First, Middle, Last) Stanley N. Lewis				18		me (First, Midd e Hurle				
MD 21; 2 should be and Men 27 is mar rewarte eve		ga. Informant's Name/Relationship (Toyce Lewis	ype, Print) wife	2	19b. Mailing 418	Address (Street Shepherd	and Number of	or Rural Route Cambri	dge,	MD 2	21613	
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medical To Be Comple	1	0a. Method of Disposition XBurial 2 Cremation 3 Donation 5 Other Specify:		te cre	matory or other	Mem. Pa	rk	Date 2/20/09	/09 Cambridge, MD			
Balti permit. Departi Import injury		Signature of Funeral Service Licensee 22. Name and Address of Facility Tho 700 Locust St., Can 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r								ral Ho MD 21	1613	
Physician Mc ci. al xaminer		failure. List only one cause on ea mmediate Cause (Final disease a.			o not enter th	e mode of dying, s	uch as cardia	ac or respirator	/ arrest, sh	nock, or hea	irt Aj	pproximate Interval etween Onset and Death
ted nsit Examiner		cause. Enter Underlying Cause	Due to (or as a conse									
ecuted n and transit	- 1 L	d.						<u>.</u>				
the death certificate be executed by the attending physician and ched for use as the burial - transit	2	FFEMALE: Bb. Was decedent pregnant in the past 12 months?	23c. If yes, outcor Live birth Pregnant at Unknown		2 Fet	al death 3 er (Specify)	Ectopic pre	gnancy	2	3d. Date of Month	delivery Day	Year
P.O. B es that the d grand by the detached by the detached by the by Phy	3	Part II. Other significant conditions	contributing to deat	but not res	ulting in the u	nderlying cause gi	ven in Part I.					cause of death?
Division of Vital Records, P.O. Box 68' within 24 hours after death To the Hospital or Attending Physician: The law requires that the death certifi To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	nalidie.							_ _ [Vas an autopsy performed? es 2	? p	Vere autops rior to comp eath? Yes	y findings available oletion of cause of
I. The rithers or, pa		25. Was case referred to medical					of Death (Che					
F Vital Physician This certi		examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other ₄ Nu	ursing Home 5	Resid	dence 6	Other: Sc	ene
on of Vital F ending Physician: 5 aut. After this certific the funeral director, 1 trion: To Be C		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigati	28b. Time of Ir 0942 hrs		y at Work? es 2 No	Sail boa	ribe how in t fell on	top of su	^{ed} ıbject			
Division or Attention and Division of Attention or Attent	The first of the f					t, factory, office bu	uilding, etc.	or To	vn, State)	and Number		Route Number, City
To the Host within 24 hc To the Funcompletely Madical C	i dica	one) 2 Medical Examine	ian: To the best of m r:On the basis of exa and manner stated.	y knowledge mination and	e, death occur d/or investigat	on, in my opinion,	death occurr	and due to the ed at the time,	date and p	olace, and d	ue to the ca	
	ĬĀ Z	29b. Signature and title of certifier When Diases	Unid			29c, License O.C.N				bruary 1	•	Day,Year)
0	13	30. Name and address of person who Melissa Brassell, MD A	completed cause of c ssistant Medica			enn Street, B	altimore, N	MD 21201				
Stat Registra	trate 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature fram FEB 2 0 2009											

State of Maryland / Department of Health and Mental Hygien ? 07184 Certificate of Death 2. Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18 2009 FEB 6:35 AM M MARY HELEN LARRIMORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE; S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) OCT 4, 1915 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F MD Yrs. 93 217-03-3378 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand of Health and Mantal Hygiene.
and of Health and Mantal Hygiene.
and: If team 23 is marked of ther then "natural", or Itema 23s or 28s-1 show ury or other traumatic event, "in Madicial Examples mount to an notified at 1 ☐ Yes 2 ☐ No Director CENTREVILLE MD QUEEN ANNE'S 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21617 UNITED STATES 140 LARRIMORE FARM LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET COLEMAN THOMAS QUIMBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 907 CHURCH HILL RD. CENTREVILLE, MD 21617 MARY HELEN WOLFE/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition CENTREVILLE, MD MON, FEB 1 X Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If ony injury or 4 □ Donation 5 □ Other (Specify) CHESTERFIELD CEMETERY 23,2009 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM, P.A. 408 S. LIBERTY ST CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aborava scular montfiziency years Physician /Medical Examiner 0215 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of Physician/Medical Examiner The law requires that the death certificate be executed anding physicien and use as the burlal-transit ears Box 68760. ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cete has been signer. pege 2 should be d Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🗷 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After To the Hospitel or Attending within 24 hours efter death. To the Funeral Director: Afte completely filled in by the fune 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified V 610 Dutchman's Lane, Easton, 32. Registrar's Signature 30. Name and address of person who completed use of death (Item 23a) (Type, Print) mowley State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** 21, 2009 FEBRUARY 0714 A MILDRED DAVIS LUDWIG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CECIL EARLEVILLE 4 BUENA VISTA DR. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. 1/10/1922 Director 87 <u>MA</u> 221-16-6884 Usual Residence of Decedent 10d. In side City Limits 10c. City, Town or Location r 28a-f show 10a, State 10b. County 1 ☐ Yes 2X No MD CECIL EARLEVILLE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Dust be Pages 1 and 2 should be filed within 72 hours after death we nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural; or Itema 23a ury or other traumatic event, it as Medical Exaction or must be 4 BUENA VISTA DR. 21919 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 12 TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEELMAN TAYLOR JAMES CORBETT DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 BUENA VISTA DR. EARLEVILLE, MD 21919 ERIC W. LUDWIG/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) tment of Department Important: If any injury or once. CHESAPEAKE CREAMTION 2/23/2009 STEVENSVILLE, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service Licenses MAIN ST. CECILTON, MD 21913 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No.

9 Unknown Month Year 4☐Pregnant at time of death ξĐ 9 Unknown cate has been signed by , page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 00 1 Yes this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending Injury To the Hospital or average within 24 hours after death.

To the Funeral Director: After the funeral by the fune 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 30 Name and address of person who completed cause of death (Item 23a) (Typer Print) OM CO 31. Date filed (Month, Day, Year) OVLa 32. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 18, 2009 **Physician** David Wayne Lancaster February 12:30 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Taneytown Carroll 5047 Babylon Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Hours Min Months 1 M 2 □ F Apr 9, Pennsylvania 184-54-2369 46 1962 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Carroll Taneytown Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21787 5047 Babylon Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, it is wedled Even 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify: ò 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Landscaping 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane E. Ritmiller Louis H. Lancaster ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5047 Babylon Road, Taneytown, MD 21787 Mary Holland-Lancaster, wife 20b. Place of Disposition (Name of Sentity, crematory or other place)
Carroll Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2/20/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Myers-Durboraw Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 ton 23a. Part1. Enter the disease, or complications that cau ed the death. shock, or heart failure. List only one cause in ea fuline. Do not ent he mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) is a contequent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ρ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA

b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P. A hours after death.
P. Atter this certificate has been signed by the attending physician and attending physician and for use as the burial-trar P.O. Box 68760. ned by the a signed to Records, Vital Division of filled in by the

Physician /Medical

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Nedical Exer, her must be rediffed at

the Maryland

Baltimore, Maryland 21215-0036

Certification: To

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 2 Accident 5 Pending investigation 1∐Yes 2∐No 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WIL 8

within 2

2

completely

of person who completed cause of death (Item 23a) (Type, Print)

30. Name and addre

Year) 32. Registrar's Sign FEB 19

29b. Signature and title of certifi

DHMH 17 Rev 1/2001

State

Registrar

License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month 19, James Lindsey /Medical February 2009 21:25 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F Director 80 248-34-8719 Dec 18, 1928 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Exertings at District of Columbia 1 XYes 2 ☐ No Directo Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3005 Bladensburg Road #302 20018 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify: Black 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. 12 years (0-12) College (1-4or 5+) Auto Salesman Self Employed permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other than any Injury or other traumatic event, Ingone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be ၉ Unknown Willie Mae Bauknight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Washington - Godson 14 Joyceton Way Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4. □ Donation 5 □ Other (Specify) Quantico National Cemt. March 4, 2009 Triangle, VA 21. Signature of Funeral Service Linense 22. Name and Address of Facility Stewart Funeral Home, Inc. 5 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock; or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** to aglaine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Mman Imm mo depung signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 1 No 3 Probably 4 Unknown n ning After this certificate has been si funeral director, page 2 should h Completed Dicheter 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 INO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 Feb 19, 2009 D0043662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, MD 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 2 4 2009

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 12:45 AM February 22, 2009 Jules Gerard Labonte, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 1 3 M 2 □ F 74 December 20,1934 Waterville, ME 006-30-9300 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show items 23a or 28a-f shov 1 XYes 2 No Director Maryland | Prince George's College Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20740 4800 Berwyn Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1953-1956 Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education within 72 | (Specify only highest grade completed) es 1 and 2 should be filed within 7 of Health and Mental Hygiene. If Item 27 Is marked other than "n or other traumatic event, the ways Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Repair Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Abraham Labonte Marie Louise Fortin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Berwyn Road, College Park, MD 20740 Marie L. Labonte / Wife permit. Pages 1 a
Department of Hei
Important: If Item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/24/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Licenses 4739 Baltimore Avenue euns Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal disease Stools **Physician** in ol /Medical Due to (or as a consequence of): Concramy Anteny disease Examiner ermi mel if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Szellla 2009 18887000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdellow im D MUKemil MUCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Feb. 17, 2009 0040 William Liff Gene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring Date of Birth (Month, Day, Year) 8 / 1 0 / 1 9 5 3 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Wash., D.C. 55 215-60-8081 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "sedical Exant and in ust be notified at MD Montgomery Silver Spring 1 □Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 USA 1111 University Blvd.West#607 Pages 1 and 2 should be filed within 72 hours after death vener of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify: ģ 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Schneider George Irving Liff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1111 University Blvd West #607 Maryland Jean Liff/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2/19/2009 Beltsville, Md 21. Signature of Funeral Service License PHITTPADS: RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Ents, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Respiratory failure resulting in death) /Medical Due to (or as a consequence of): Examiner Pleural effusion Sequentially list conditions, Examiner Due to for as a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director. After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Metastatic lung cancer
Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ Yo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No i∐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hospi within 24 hou To the Funer completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

2009

Delroy Angelin MD

FEB 2

31. Date filed (Month, Day, Year

D55148

1500 Forest Glen Rd Silver Spring, Md 20910

Feb. 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 18, 2009 Michael Elmer Long, Sr. 4:45 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Huntingtown 1231 Matthew Drive Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, 1939 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min 244-58-2850 1 X M 2 □ F 69 Iowa Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country's 10e Street and Number 1231 Matthew Drive 20639 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Network Engineer

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Of Defense

Approximate Interval Between Onset and Death

months

Year

20c. Location - City or Town, State

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

0

Clinton, Maryland

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Feb^{Date}21

2009

1231 Matthew Drive Huntingtown, MD 20639

Charlotte Sergia Selheim

Physician /Medical **Examiner**

Department of Health an Important: If item 27 is any Injury or other trau

Pages 1

Physician

Examiner

Funeral

Director

and 2 should be filed within 72 hours after death with the Marylan teath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Evandon mantale to natified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Elmer Eugene Long.

Jean Long (wife)

4 □ Donation 5 □ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

1 Burial 2 Cremation 3 Removal from State

Jr.

Licensee John F.

MO1464

Director

Funeral

\$

Completed

Be

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9 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Paneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical 9 Completed Be Certification: To

^{22. Name and Address of Facility}Lee Funeral Home Calvert, P. 8125 Southern Maryland Blvd. Owing, MD 20736 Part 1. Enter the disease, or complications that c. ds. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 25No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. Medical 29a, Certifier 2 Medical E 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D51949

Holmes

State Registrar

within 2 To the

31. Date filed (Month, Day, Year) FEB 20

David R. Gallatin M.D.

32. Registra s Signature 2009 ▶ Deneur

30. Name and address operson who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road Prince Frederick, MD 20678 park

			For State Registrar	State	of Marylar		artment <i>rtificate</i>			ınd M	-	giene Reg. No. 2	009	07191
	Dharaisi		1. Decedent's Name (First, Midd	fle, Last)							2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		Catherine Le	wis						I	Februai	ry 13,	2009	1231P M
	Examin	er	4a. Facility Name (If not institution				4b. City, To			f Death		4c. Co	unty of Death	
,,,	_		Southern Mary 5. Social Security Number	Land Hosp:	lta⊥ 7. Age <i>(In yrs</i> .	last hirthday)	If Under 1	into	on If Under 2	94 Hrs. T	8. Date of Bir	th	PG a Riethe	place (State or Foreign
	Funeral Director		577–54–6223	1 □ M 2 🔀 F	70	Yrs.		Days	Hours	Min.	08/27/	1938	Couit	yland
	ס		Usual Residence of Decedent		70									7
	ırylan show	_	10a. State 10b. Count	•	10c. Ci	ty, Town or Lo							1	0d. Inside City Limits
	Ba-f s	cto	MD PG			Land	over							Yes 2∏No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If I tem 27 is marked other than "natural", or Items 23a or 28a-f show of I tem 27 is marked other than "natural", or ther traumatic event, I'm I'm edical Eventral to notified at	Funeral Director	10e. Street and Number 7610 Muncy Ro	ad			10f. Zip C	2078	35			_	of What Cour USA	ntry?
	r dea	ne l	11. Marital Status	12. Was De	cedent Ever in U		Was Decede f Yes, specif	nt of Hisp Cuban,	panic Orig	gin? (Spec	cify Yes or No Rican, etc.)		Race - Americ Black, White,	
36	, or It	by Fi	1 Never Married 2 Ma	If Yes, G	2 y No live		I □Yes 2		Specify:				ecify: Bla	
21215-0036	hour tural	pa pa	3 Widowed 4 Divorce	1 1 1 1 1 1	Dates:	16a Dece	dent's Usual	Occupati	ion				of Business/In	
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pu	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle	, Last)				1	8. Mother	r's Name	(First, Middle,	, Maiden Sui	rname)	
Maryland	ould by Ment narked	오	Robert Lee			1					Eliza			
Ma	d 2 st th an 17 is r traur		19a. Informant's Name/Relation Alexander Kale		andeon		_				ol Hei		wn, State, Zip	
a)	os 1 and 2 of Health a of Item 27 is r other tra		20a. Method of Disposition	iluci – Gir	20h	Place of Dispo	sition /Name	of		Da	ate		ion - City or To	743 own. State
altimore,	permit. Pages 1 Department of I Important: If Ite any Injury or ot once.		Burial 2 Cremation	3 Removal from	State Qua	cemetery, crer	natory or oth Nation	er place) al C	Cem 0	3/02	/2009			irginia
ij	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Serve						1		an Funer		_	
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			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the dea	th. Do not ent	er the mode	of dying,	such as	cardiac or	r respiratory a	irrest,		Approximate Interval Between
3	Physician		Immediate Cause (Final disease occondition	A	10.40	mo	60.04	600	6	Z	sahe	m.50		Onset and Death
me (/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):		,/	-		sche			
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Due to	o (or as a consec	quence of):								
	execun and al-train	Exar	that initiated events resulting in death) Last	c	o (or as a consec	quence of):								
8760,	ficate be executed physician and s the burial-transit	dicall		L _d										
	tificat ng phy as th	00 1												
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pre	anancy				23d	. Date of deliv	,
O. E	ne dea the at hed fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowh		gnant at time of		Other (spe		-				Month	Day Year
<u>P</u> .	that the	Phy	Part II. Other significant condit	iene contributing to	dooth but not you	volting in the co	ada uk ina a sa		in Don't		220 Did t	lahassa usa	a a mánilos da da d	he cause of death?
Records,	es ign be	l by	rattii. Other significant condi	ions contributing to	dealif but not res	saiting in the a	ilderlyllig cac	ise given	III Fait i.			Yes 2□N		
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Vital	i clan: The certificate ha	င်	25. Was case referred to medic	al I							1 □ Yes	2 X No	1 ☐ Yes	2 □No
=	Physician: r this certifici ral director, p	00	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	2 DOA	Othor			(Check only o		1011 10 1	
	g Phys er this eral dir	n: To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o		c. Injury a Work?	4 🗆 Nui		8d. Describe		Other (Special courred	<u>(y)</u>
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Division	r Atte er de: recto recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory,	office		2	8f. Location (Street and N	umber or Run	al Route Number,
莅	Hospital or 24 hours afte Funeral Directly filled in it									į				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	Ing Physician: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated	owledge, deat ation and/or in	h occurred a vestigation, i	t the time n my opii	e, date an nion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) an date and pla	d manner as s ace, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certification				29c.	License r	number			29d. Date s	igned (Month,	Day, Year)
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^	1		30 Name and address of perso	n who completed car	use of death (Ite	m_23a) (Type,	Print) - 1		1 1	<u></u>	0		14-00	1
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-	/		31. Date filed (Month, Day, Year	202 001	Registrar's Sign		Cura		1, 14		-			

09-01624 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Veronica L. Long State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 25, 2009 0018 hrs Medical Examiner Veronica Lee Long 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital Frederick Frederick If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year **Funeral** 5. Social Security Number Age (In yrs. last birthday) Washington Months Days Hours Min Director 217-72-8722 50 October 7. 1958 Country) 1 M 2X F Yrs Usual Residence of Deceder 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Frederick 1 Yes 2 X No I jamsville or items 23a or 28a-f show must be notified at once, Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2312 Oak Drive 21754 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican. etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White Yes 2 X No specify: Give Yea Widowed 4 Divorced altimore, MD 21215-0036
mir Pages I and 2 should be flied within 72 hours after any arment of Health and Mental Hygiene.
vortant: If item 27 is marked other than "natural". traumatic event, the Medical Examiner "natural". á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Disabled Disabled 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanette Lee Bellanger Raymond E. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette L. Bellanger / Mother 2312 Oak Drive. Ijamsville, Maryland 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, February 26, crematory or other place) Removal from State Burial 2 X Cremation 3 2009 Smithsburg Crematory Smithsburg, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford PA Funeral Home, Shawn M. Johnson (PerDvr) M01473 106 Fast Church Street Frederick 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating arrest, shock, or near Maryland 21701 Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Acute coronary artery thrombosis Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause re death certificate be executed to attention (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 23a,PII,2/,perME Item#21perFH ,G88 g890 4/9/ 3/5/09,WS X UNPENDED erME, ,G889 attending physician or use as the burial IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ≥ Atheroslerotic cardiovascular disease Yes 2 No 3 Probably 4 ✔ Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✔ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient

Hospital or Attending Physician: Division of Vital

within 24 hours after death To the Fineral Director: the in by

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Certification:

2

3

4

1 ✔ Yes 27 Manner of Death

Accident

Suicide

Homicide 29a. Certifier

1 X Natural

OKberg State Registra

Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 30. Name and address of person who completed cause of death (Item 23a) ssistant Medical Examiner Theodore M. King, Jr., MD.

Pendina

Investigation

Could not be

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME February 25, 2009

or Town, State)

28d. Describe how injury occurred

28f, Location (Street and Number or Rural Route Number, City

111 Penn Street, Baltimore, MD 21201

28c. Injury at Work?

Yes 2 No

32. Registrar's S

28a. Date of Injury (Month, Day, Year

(Specify)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:27 A 2-20-2009 Donald Roy Mathieu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 M 2 F Director 8-9-1929 AL <u> 264–38–6665</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Howard Highland Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 13180 Rt. 108 20777 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Date £948-53 72 hours after 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Analyst NSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Price ည Donald R. Mathieu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health as Important: If item 27 is any Injury or other trau once. Hilda Mathieu / Wife 13180 Rt. 108, Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify Ardent Cremation 2-26-2009 Hanover, MD 21. Sign tur of Funer y 22. Name and Address of Facilit Harry H. Witzke's Family FH, Inc. M00845 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart Attack disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Cardiac Arrythmias burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, p 1 Yes 2 No 3 Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb. 20, 2009 D0044763 of person who completed cause of death (Item 23a) (Type, Print) Dr. F. Salvador Martinez 5755 Cedar Lane Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 24 barker Registrar

State of Maryland / Department of Health and Mental Hygien) 1 9 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William A. Molali February 20, 2009 2030 /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner lavre de Grace

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Vanch 21. 1928 | 9. Birthplace (Country)

Voungtown, Ohio 1500 Troquois Court Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**XX** 2□ F Yrs. 280-20-8988 Director 80 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. Count **ehow** 10a State 27 is marked other than "natural", or Itama 23a or 28a-f ehov traumatic event, the Modical Exertinat must be notified at 1 Tyes 2 □ No Director Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1500 Iroquois Court U.S.A. Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1. No 14. Race - American Indian Black, White, etc. Pages 1 and 2 should ba filed within 72 hours after onent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Manufacturing Chimney Stacks 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Patia Kirkomoli James Molali 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 is any injury or othar trau 2005. - Wife Norma Molali 1500 Iroquois Ct. Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Holy Thinkly Episcopal 02/24/2009 Havre de Grace, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home. P.A. 21. Signature of Funeral Septice Lice 123 S. Washington St. Havre de Grace. MD. 21078 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final CARDIAC ARRES1 Physician MINUTES disease or condition resulting in death) /Medical Examiner CAROLO MY OPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lot as a consequence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No Division of Vital 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending efter death. Diractor: Aft 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 23, 2009 D22097 address of person w completed cause of death (Item 23a) (Type, Print) 555 ALUANCE ST. HAVRE DE GRACE, MARTLAND 21078 BARRY WOHL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 5 2009 Registrar

			For State Registrar		Sta	ate of M	arylan	d / Depa <i>Ce</i>	artmen rtificat			nd Me	ntal Hy	giene Reg. No.	200	19	071	95
			1. Decedent's Name	(First, Midd	le, Last)							2.	Date of De	ath			3. Time of D	eath
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	Examir		4a. Facility Name (If	not institutio	n, give street	and number)			4b. City,	Town, or	Location of	Death			County of [
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	Funeral		5. Social Security Nu	mber	6. Sex 1 □ M 2			last birthday)	If Under Months	1 Year Days	If Under 24 Hours	Min	Date of Bir (Month, Da	th ay, Year)	9.	Birthpl Count	ace (State or I	Foreign
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	and		Usual Residence of D	Decedent 10b. County			10c. Cit	y, Town or Lo	cation							10	d. Inside City	Limits
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M;115	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, In a Magane."		20a. Method of Dispo	sition			20b. F	Place of Dispo emetery, crei				Date			cation - City	or Tov	n, State	
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	es the	<u>م</u>	Part II. Other signific	ant conditi	ons contributi	ng to death b	out not resi	ulting in the u	nderlying c	ause give	en in Part I.						cause of dea	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (ng Physician Examiner: C		of examina											
	To the vithin To the complete	Me	29b. Signature and ti	ile of certific		,	1.		290	. License	e number			29d. Date	e signed (M	onth, E	ay, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician Christine Messick Mary 2136 PM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3441561 M VICOM 10 TENINS4UA ROGIONAL MEDIOGL If Under 1 Year | If Under 24 Ars. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F Months Days Hours 50 220-68-8648 Director 12/02/1958 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10h. County f show 10a. State r items 23a or 28a-f shov inversioust by notified at Wicomico Salisbury 1 ☐ Yes 2 X No Director Maryland 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 21804 USA 512 Barnsdale Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Specify: white the Medical Ever Completed by 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) child care day care provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Meilhammer Sr. Mary Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Barnsdale Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Jerry Messick Sr/husband item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/21/09 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 anature of Funeral Service Licensee dompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) ASCUD Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): g physician a Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Seizure & Dade 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed oligodendro gliona 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No ospital or Attending Physician: hours after death. After this certification, g 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DCA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State

Registrar

100 €

arroll St. Salisbury ma 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.R.M.C.

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day William Harry McClellan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 146K6411 TENINSULA REGIONAL cente VICOMIC Medical Social Security Number Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 X M 2 □ F 05/07/1945 New Jersey Director 614-34-9355 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm I'm I and Examinating at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2316 Hudson Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 X Yes 2 □ No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: Specify: white ð 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) glass cutter glass company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. McClellan Jean Anne Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Naill/daughter 2938 Old Sharptown Rd., Laurel, De 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 02/20/2009 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 nature of Funeral Service Licensee CFSP and Hompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** un9 /Medical Due to (or as a consequence of): Examiner mona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical nse : IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for P.0. 1 ∏Yes 2 ∏No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 4100 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? or Attending 5 Pending To the Hospital or Autenamenthin 24 hours after death.

To the Funeral Director: A feempletely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 2-11-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 21 2009 9:50p Virginia S. Moss 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey Hospice House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Months Days 1 ☐ M 2 🛣 F 11/25/1919 224-28-3974 89 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1X Yes 2 □ No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20902 USA 1013 Cresthaven Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William G. Moss Virginia A. Sayers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Wadosky - niece 109 Cypress Point, Hendersonville, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State Fort Lincoln Cem. 2/24/2009 4 Donation 5 Dother (Specify) Brentwood, MD Ande License 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

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items 23a

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, I wane.

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

n 24 hours after death.

• Funeral Director: A pletely filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner Be

Medical Certification: To

shock, or heart failure. List only	one cause on each line.	Interval Between Onset and Death
Immediate Cause (Final disease or condition	Aspiration Pneumonia	Offset and Death
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or Injury	b Due to (or as a consequence of):	
that initiated events resulting in death) Last	C	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
-	,, , , , , , , , , , , , , , , , , , , ,	cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☒ Unknown
	24a. Was an autopsy performe 1	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence	ce 6 Stother (Specify) Hospice
27. Manner of Death 1 ∰ Natural 5 ☐ Pending 2 ☐ Accident investigation		injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, Street)	et and Number or Rural Route Number, State)
	niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	
29b. Signature and title of certifier	M.D. 29c. License number 29d	Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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within 2 To the

6001 Muncaster Mill Rd., Rockville, MD

20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski,

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

DHMH 16 Rev 6/95

				State of M	aryland		epartment of the Certificate of		мептат ну	giene Reg. No. U	09	07199
F	Physicia	in	1. Decedent's Name (First, Middle, I Dallas Wilson						2. Date of De Month JAN.		2009	3. Time of Death 12:25 AM
١,	/Medic Examin		4a Facility Name (If not institution, g					4b. City, Town, or I			unty of Death	12:25 AH
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	uneral rector		217-30-9478	.Sex 7.Ag Mg∏xM 2□ F	je (<i>I</i> n <i>yrs. l</i> e 7 :		Months Davs		8. Date of Bin (Month, Da June 1	th i <i>y, Year)</i> 3 , 193	9. Birthr Cour 35 Mai	place (State or Foreign htry) cyland
death with the Merylend	a or 28a-f ahow be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Carol	line	10c. City	, Town o	r Location Feder	alsburg			1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th the	or 28a	Frec	10e. Street and Number		1		10f. Zip Code			10g. Citizen	of What Cour	ntry?
ath w	2 3	ral	27319 Willin					21632			ed St	
within 72 hours efter de ane.	al', or itame Examiner m	by Funeral Director	11. Marital Status 1 □ Never Married Z□XMarried 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X 1 Yes, Give Year or Dates:		S	 Was Decedent of I if Yes, specify Cub Yes 2√ No 		pecify Yes of No o Rican, etc.)		Race - Americ Black, White, ecify: W	
2 P P P P P P P P P P P P P P P P P P P	natural', edical Exe	Completed	15. Decedent's (Specify only highest g	Education arade completed)		16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of wor	king	16b. Kind	of Business/In	dustry
Afthin 16.		mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		ife. <i>DO NOT use retire</i> lesman &			Fede	ral P	aper Co.
g g v	ant, th	Be Co	G.E.D. 17. Father's Name (First, Middle, La.	st)		Da.	resman a	18. Mother's Nan	ne (First, Middle	1		
should be	marked on	To B	James Frankl	lin Moore	, Sr	•		Flore	nce E.	Jone	s	
2 sho	7 is marked other than traumatic avant, the M		19a. Informant's Name/Relationship				Mailing Address (Street			-		
1 end Health	CI L	ŀ	B. Ann Moore/ 20a. Method of Disposition	Spouse	20b. Pl	1	319 Willi hisposition (Name of crematory or other pla		Peder		ion - City or To	
Peges ant of	y or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				crematory or other pla rest Ceme		1/31/09			urg, MD
permit. P	Important: If Item any Injury or othe once.		21. Signature of Funeral Service Lic		,		22. Name and Addre		amptom	Fune	ral H	ome
		-	23a. Part1. Enter the disease, or co	mplications that caused	the death	. Do no					burg,	MD 21632 Approximate Interval Between
/Me	sician edical		shock, or heart failure. List on Immediate Cause (Final disease or condition			171	c PRO:	STATE	- 0	W E	-R	Onset and Death
Exa	miner	١	resulting in death)	a			nsequence of):	77.70		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,0,,0
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that tha d	ed by the datached	y Physician/M	Part II. Other significant conditions	contributing to death b	ut not resu	rting in tr	ne underlying cause gr	ven in Part I.		Yes 201	/	o the cause of death? bably 4 Unknown
The law requires that the death cert	To the Funeral Diractor: After this certificate has been signed by the attending completely tiliad in by the funeral director, pege 2 should be datached for use a	Completed by							24a. Was	an autopsy med?	av	ere autopsy findings ailable prior to mpletion of cause death?
The la	ate ha	E							1 🗆	Yes 2	10 10	☐Yes 2☐ No
clan:	ertifica ector,	Be	25. Was cese referred to medical examiner?	No acital:				26. Place of Dea	ath (Check only	one)		
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or Attandate after deat	Diractor: d in by the	Certification:	2 Accident 3 Suicide 6 Could not determine	be one Diese of Inc	ury - At hor	me, farm	n, street, factory, office		28f. Location (City or To		lumber or Rura	al Route Number,
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To the	To the comp	Ž	29b. Signature and title of certifier	1	. ^	1)	29c. Licens		10-		igned (Month,	1
				MM	/		CL-	-0008	433	2	127/	09
			30. Neme and address of person who Salman Fl Hasi		leath (Item	23e) (Ty	iddleford R	ed. Suite 2	02, Se	eford,	DE 19	973
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ure	arke					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mollie MELAMED 18, 2009 **Physician** February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 29, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕠 F Poland 093-16-5354 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 28a-f shov 1 □Yes 2 No Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examine must he it 10422 Burnt Ember Drive 20903 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2X No <u>ک</u> 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Greenberg Eva Cohen မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10422 Burnt Ember Drive, Silver Spring, MD 20903 Lesley Melamed, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I-Important: If ite any Injury or ot 1) ☐ Buriai 2 ☐ Cremation 3 💢 Removal from State Beth David Cemetery 02/22/09 Elmont, New York 4 Donation 5 Dother (Specify) 21. Signature of Finer i Service icensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Respiratory Failure /Medical Due to (or as a consequence of) Examiner Severe Interstitial Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a collisequence of). or Attending Physician: The law requires that the death certificate be executed Exami Severe Sepsis physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 ☑ No 9 □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 19, 2009 D 63579 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marie J. Tayag, M.D., 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 20 Registrar

			For State	State of	Maryland		artment of F		and Me		giene Reg. No. 2	009	07	201
			Registrar 1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath			of Death
	Physicia /Medic		Leon Mark	kowitz					F	Month Februar	y 17,	2009	1:57	А. М.
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ď			Montgomery Ge				Olney If Under 1 Year	I If I Indos	24 Uro T	D-1(D)		ntgom	-	
	Funeral Director		5. Social Security Number	6. Sex 7. 1 XM 2 ☐ F	Age (In yrs. la	ast birthday) 90 Yrs.	Months Days	If Under Hours	Min.	8. Date of Birt (Month, Da April 2	in 21, ^{Ye<i>ar</i>)} 191	9. Birti Coi 18 Ma	nplace (State untry) arylan	e o <i>r Foreign</i> d
			548-12-2715 Usual Residence of Decedent							TPLIL 2				
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	with the		10e. Street and Number 23501 Rolling F	ork Way			10f. Zip Code	882			10g. Citizen	S. A		
	ms 23	Funeral	11. Marital Status	12. Was Decede		3. 13.	Was Decedent of H		igin? (Spec	cify Yes or No-	1	Race - Amer	rican Indian,	
ဖွ	filed within 72 hours after death with the Maryland Hygene. Hygene, than "natural", or items 23a or 28a-f show ent, I'm Modest Evaminer must be notified at		1 ☐ Never Married 2 ☐ Marr	ried Armed Force	□ No Arm	У	if Yes, specify Cub 1 □Yes 2 🕱 No			ican, etc.)		Black, White		
003	ural",	d by	3 ₩ Widowed 4 □ Divorced	Year or Date	es: Airf	orce							Thite	
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yla	should be f and Mental I s marked of umatic eve	ပ	Abraham Marko			T				enderso				
	Cl		19a. Informant's Name/Relations Barry L. Marko			19b. Mailir 2350	ng Address <i>(Street</i> 1 Rolling	and Numbe g Fork	er or Rural x Way	, Gaitl	<i>er, City or To</i> hersbu	$_{ m rg}$, $_{ m Mg}$	ip Code) arylan	d
ē,	thand Health tem 27 other to		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of	;	Da		20c. Location		1002	
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alti	permit. Departm Importa any inju		21. Signature of Funeral Service				2. Name and Addre					pels.	Inc	
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			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	ised the death th line.	. Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory ar	rrest,		Approxim Interval B Onset and	ate etween d Death
and a	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a 5 2	psis									
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8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a consequ	ience of):								
687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d										
Box (leath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7				23d.	Date of deli	very	
Ö.	e death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2□Fetal nt at time of de		☐ Ectopic pregnand ☐ Other <i>(sp</i> ec <i>ify)</i> _					Month	Day	Year
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SO	w requir s been si should I	letec								24a. Was	an 2/	th Were au	topsy finding	re available
Vital Records,	/sician: The law s certificate has t lirector, page 2 s	Completed								autop perfo	osy rmed?	prior to death?	completion of	cause of
		Be Co	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 - Ko	1 ∐ Yes	2 🗆 No	
>	Physic this ce al direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inc	oatient 2 □ I	ER/Outpatie	nt 3 □ DOA Oth	ner: 4 🗆 Nu	ursing Hom	ne 5 ☐ Resid	dence 6 🗆	Other (Spec	cify)	
Ē	ding Ph h. After th funeral	:uo	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	'y	Injury Day, Year)	28b. Time o Injury	Wor			8d. Describe h	how injury occ	curred		
Division of	or Attend after death Director: , i in by the f	icati	2 Accident investig 3 Suicide 6 Could	not ho	f Injury - At ho	me farm str		lYes 2□		8f. Location (S	Street and Ni	imher or Ru	ral Route Ni	ımher
<u>></u>	after catter control Director din by	Certification: To	4 ☐ Homicide determ	ined building	, etc. (Specify	<i>')</i>	eet, factory, office			City or Tov	vn, State)	inibor or rid	rar riodio ric	
	to the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	(Check only 2 Medical	ng Physician: To the be Examiner: On the bas	est of my know is of examinat	wledge, deat	h occurred at the to	ime, date ar	nd place, a ath occurre	and due to the	cause(s) and	d manner as ce, and due	stated.	e(s)
	To the Hos within 24 h To the Fun completely	Med	one) 29b. Signature and title of certifie	and manne	r stated.		29c. Licens	se number			29d. Date sig	ned (Month	n. Dav Year)	
	o with		► C. Z	6, 1	11		D	359	115		2 ~	17-	-20	
	, •		30. Name/and address of person		of death (Item	23a) (Type,	Print)	и /	721	000	Hos	n) La	(
			31. Date filed (Month, Day, Year)	2 hang	, gistrar's Signat	11/1011	John	1 6	1810	y we	11-7	p i i w		
I	Sta Registr		FFR 2 0	2009		. pa	the							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	e of Maryland		rtificate of i		-	gierre Reg. No	109	07202
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and	I. Marti	n .	4h City Town o	r Location of Death	Februa	_	2009 nty of Death	1:35 P ^M
j	Examin	er	Calvert County Nursing				Frederick	:		vert	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th y, Year)		lace (State or Foreign htry)
	Director		215-22-7147 Usual Residence of Decedent	90	Yrs.			05-28-	-1918	Mary	land
	/land ow at		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Mar a-f sh tified	ctor	MD Calvert			Dunkirk					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		ntry?
	eath v	eral	9618 Cortland Lane	Decedent Ever in U.S	3 13 1		754 lispanic Origin? (Sp	ecify Yes or No	US - 14. B	A lace - Americ	an Indian.
"	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married 1 1	ed Forces? Yes 2 X No s. Give		If Yes, specify Cuba 1 □ Yes 2 🖔 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	В	lack, White,	
<u>8</u>	ural", c	d by	3 🖾 Widowed 4 □ Divorced Year	or Dates:			, ,		Spec	whi	
15-	"natu	lete	15. Decedent's Education (Specify only highest grade comple		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of	Business/Ind	dustry
72	l withii jiene. r than the M	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	homer		-7		own	home	
nd	al Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surn	ame)	
yla	ould to	٩	Ora Harn		101 14 11		Bessie				Riley
Maryland 21215-0036	id 2 sk lth and 27 is n traun		19a. Informant's Name/Relationship (Type. Print, Shirley Martin, daught			,	and Number or Rur d Lane, I				(Code)
ē,	of Hea		20a. Method of Disposition	20b. Pl		sition (Name of matory or other place		Date		n - City or To	own, State
<u>E</u>	Page nent c ant: If ury or		1 X Burial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (Specify)	irom State			ery 02-23	3-2009	Brentw	rood, N	1D
Baltimore,	permit. Departr Imports any Inj once.		21. Signature of Funeral Service Licensee			2. Name and Addre		ausch F			
	⊕ □ = ® Ø	1 1	23a Part Enter de disease or complications t	hat caused the death			Harmony I			MD 207	
	Physician		23a. Part . Enter the disease, or complications t shock, or beart failure. List only one cause Immediate Cause (Final				lio vasi				Approximate Interval Between Onset and Death
,	/Medical		disease or condition resulting in death)	e to (or as a consequ		c cura	10 Ves	uiei	US FECE	+	
8	Examiner		Sequentially list conditions, b								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (ur as a consequ	ence ury:						
oʻ	execu an and rial-tra	Еха	that initiated events resulting in death) Last C	e to (or as a consequ	ence of):						
68760,	ficate be executed physician and s the burial-transit	edical	d								
_		Mec	IF FEMALE: 23c. If yes	s, outcome pf pregnar	ncv				224	Data of deline	
Вох	that the death certified by the attending detached for use a	Physician/M	in the past 12 months?	_ive birth 2 ☐ Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	/			Date of delive Month	Day Year
P.O.	at the by the tacher	hys	9 □ Unknown	Jnknown							
	The law requires that the tee has been signed by the hage 2 should be detache		Part II. Other significant conditions contributing Diubetes McDi		-		en in Part I.	23e. Did t			ne cause of death?
Š	v requi	eted			The	01/4		24a. Was			
Division or Vital Records,	he lav e has age 2 a	Completed by	Advance Dem	nentice.				auto perfo	psy prmed?	prior to cor death?	psy findings available mpletion of cause of
ţa	ian: T	Be C	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes h (Check only o		1 □ Yes	2 NO
۲ V	Physician: r this certific ral director,	ToE	1 ☐ Yes 2 ☑ No Hospital:	1 Inpatient 2 E			4 Let Nursing Ho				y)
on C	ding P. I. After t		1 Matural 5 ☐ Pending	Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ☐ No	28d. Describe	how injury occ	urred	
/isi	Attending ir death. ector: After by the fune	Certification:	3 Suicide 6 Could not be determined 28e. F	Place of injury - At hor	me, farm, str		103 2 10	28f. Location (Street and Nu	mber or Rura	al Route Number,
á	s after al Dire	Certi	4 ☐ Homicide determined	building, etc. (Specify	9			City or To	wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying Physician: T (Check only one) 1 ☐ Certifying Physician: T 2 ☐ Medical Exeminer: One and								
	ro the within ? го the	Mec	29b. Signature and title of certifier			29c. Licens			29d. Date sig		
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1	m) =		30. Name and address of person who completed	cause of deeth (Item	23a) (Type,						
	W.5	to	5851 - Deale C 31. Date filed (Month, Day, Year)	Musch je 32. Registray's Signat		2000	Deale	mI). 20	1270	
	Sta Registr		FFR 2 0 200	10 1	6	1	*				

2009 07203 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day February 18, 2009 1230 hrs McCullough Alice Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles 5207 Grunion Place Waldorf 9. Birthplace (State of 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Foreign Pennsylvania Months Days Hours Min Director 196-20-4082 1/17/1929 м 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No 28a-f show Maryland Waldorf Charles notified at once. the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20603 USA 5207 Grunion Place 23a with. Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. e Armed Forces' death ' 1 Never Married 2 must | Married 2 X No Yes Specify: White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after of nent of Health and Montal Hygiene, and if the and and the standard, of ant: If time 27 is marked other than "natural", of or other traumatic event, the Medical Examiner. , Give Yaar 3 X Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Orthodontist Office Office Manager 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Barnes Be Creasy Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 625 Pommander Walk Alexandria, VA. 22314 Jamie Lynn McCullough/Daughter 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, X Burial crematory or other place) Cremation 3 Removal from State 3/2/2009 Arlington Nat. Cem. Arlington, Virginia Department
Important:
injury or of Don Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 6160 Oxon Hill Road Oxon Hill, MD. 20745 also art I. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only an ecause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease Completed 24a. Was an 24b. Were autopsy findings available Diabetes Mellitus prior to completion of cause of autopsy certificate has performed? death? No Yes 2 No Yes 2 1 1 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Hospital: 1 Other, Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 this 1 ✔ Yes Certification: To After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 V Natural Yes 2 No Pending Director: d in by the f hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. February 19, 2009 my 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registra

's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar	,,	Cei	rtificate of	Death	R	eg. No.2009	07204
	Physicia	an	1. Decedent's Name (First, Middle, La.		10	. 0	2	Date of Dea Month	Day Year	
	/Medic		Constance		thae			Feb	23 2000	
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	Redic	al Carte	r Location of Death	mole	4c. County of Dea	atn
	Funeral			Sex 7. Age (In yrs. i		If Under 1 Year		Date of Birth (Month, Day		rthplace (State or Foreign
	Director		214-32-4003	□M 2X F 74	Yrs.	Months Days	Hours Min.	uly 31	, 1934	Maryland
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	ō		ington			erstown			1 □Yes 2√2 No
	r 28a-	Director	10e. Street and Number	1119 0011		10f. Zip Code	22007711		0g. Citizen of What C	ountry?
	h with	al D	13716 Hurd 1	Road		21	1742		U.S.A	A .
	r dear	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spect an, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinat must be profified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1∐Yes 2 ∏ No	Specify:		Specify:	White
9	2 hour	ted	15. Decedent's Ed	ducation		dent's Usual Occup	pation during most of working		16b. Kind of Busines	
218	within 7. jene. • than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			
121	led wi lygier her th nt, Il		11 1 17. Father's Name (First, Middle, Last,			Homemak	18. Mother's Name (i	First Middle	Home Maiden Surname)	
Maryland 21215-0036	ould be fi Mental I arked ot atic ever	o Be	Charles E				_ `		A. Null	
ary	2 should be and Mental is marked aumatic ev	ပ္	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	and Number or Rural I			Zip Code)
N.	and 2 ealth a n 27 is ner tra		Aaron C. Michael	(Husband)	1371	6 Hurd Rd	d. Hagersto	wn, Ma		
Baltimore,	= = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other plac	Dat Febru		20c. Location - City o	
Ë	t. Pag tment tant: ljury c		4 □ Donation 5 □ Other (Specif	(y) Sm:		rg Cremat	ory: 28, 2	009		g, Maryland
Bal	permit. Pages 1 Department of H Important: If Ite any injury or of		21. Signature of Funeral Service Lice	MO14.		2. Name and Addre			vis Funera	al Home cyland 21783
		\subseteq	23a. Part 1. Enter the disease, or com	plications that caused the deatl						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	_	ton.	disease	ر		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ueries of):	need	0 - 0 - 0 - 2 -			
	Examiner	L	Sequentially list conditions.	b. Hypox	a					
7	led isit	Examiner	Sequentially list conditions, if any, leading to infine dat cause. Enter Underlying Cause (Disease or injury	Disinity (Under a donneeux		(Ca)				
MA	execut and al-trar	Exan	that initiated events resulting in death) Last	c. Freum Due to (or as a consequence)	uence of):					
68760,	icate be executed physician and the burial-transit			d. Myoco	rdia	l Inb	-archion			
	ertifica ling ph e as th	Medical	IF FEMALE:	U				-		
Вох	eath ce attendi for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	l death 3[Ectopic pregnanc	Э		23d. Date of d Month	elivery D <i>a</i> y Year
Ö	the de	Physician/	1 □ Yes 2 □ Mo 9 □ Unknown	4 ☐ Pregnant at time of o 9 ☐ Unknown	leath 51	Other (specify) _				
٠ <u>.</u>	N requires that the dispension is been signed by the should be detached		Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	quires en sig uld be	ed by						1 🗆 Y	es 2 No 3	Probably 4 Unknown
of Vital Records,	2 38	Completed						24a. Was a	an 24b. Were	autopsy findings available o completion of cause of
<u>د</u>		Con						perfor 1 □ Yes	med? death? 2 1 □ Ye	? es 2□No
Vita	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	mayos	lott	26. Place of Death (
of	Phys er this eral dir	<u>1</u>	1 ☐ Yes 2 ANo 27. Manner of Death	28a. Date of Injury	28b. Time o	III 3 L DOA	4 I Nuising Home		ence 6 Other (Sp ow injury occurred	pecify)
ion	vtteriding deach. ctor Affe y the fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month, Day, Year</i>) n	Injury		'K?]Yes 2 □ No			
Division	Hospital or Attending 24 hours after death. Funeral Director After stely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, st	reet, factory, office	28	f. Location (S City or Tow	itreet and Number or i n, State)	Rural Route Number,
	urs af eral Di	Ce	Con Continu	businism. To the best of muckey	uuladaa daa	th accurred at the t	ima data and place as	ad due to the	coupe(s) and manner	no stated
	e Hospital or Attending Ph 24 hours after death. e Funeral Director. After th letely filled in by the funeral	edical		hysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	
				Cordones		事中	22180		Feb 23,	2009.
	4		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	57 Ball			
	1	i e	31. Date filed (Month, Dak Beaf) Q	n d a CO nnn 32. Redistrar's Signa	aa S	GREEN	ST Ball	MOR	EMD	21701
	Sta Registi		S (D) MIRITING	and Jenna	P. 6	Barley)				

			1 - State Registrar	230,25,27,28a	Certificate	of Death	and Re	g. No.	01203			
	Physici	an	1. Decedent's Name (First, Middle, Las) M.,			2. Date of Death Month	Day Year	3. Time of Death			
	/Medic	cal	4a. Facility Name (If not institution, giv.). /////	LK Sin To	own, or Location of Deat	02	17 2009 4c. County of Death	025/M			
	Examin	er	111MI+6 - MI-MA	10101 PAMI	011/5 AL	mBDO I AN I		ALI EGAN	14			
	Funeral		5. Social Security Number 6. S		s. last birthday) If Under 1	Year If Under 24 Hrs Days Hours Min.		9. Birthpl Year) Count	ace (State or Foreign			
	Director		220-32-4626 Usual Residence of Decedent	^{x M 2□ F} 72	Yrs.	,,	Jul 21,	1936	MD			
	rand ow at		10a. State 10b. County		City, Town or Location	<u> </u>		10	Od. Inside City Limits			
	a-f sh	ctor	MD Alleg	any	Cumberlai	nd			1 □Yes 2 □ No			
	or 28%	Dire	10e. Street and Number		10f. Zip C		10	g. Citizen of What Count	try?			
	ath w	Funeral Director	913 Lexington A			21502	>	USA				
	ter de items iner n	Fune	11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No		nt of Hispanic Origin? (S y Cuban, Mexican, Puer	to Rican, etc.)	14. Race - America Black, White, e				
036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	þ	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 [□ No Specify:		Specify: Wh	nite			
5-0	72 hc "natu	Completed	15. Decedent's Ec (Specify only highest gra	lucation ide completed)	16a. Decedent's Usual ((Give kind of work) life, DO NOT use	done during most of wo.	rking	6b. Kind of Business/Ind	ustry			
121	within jiene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Dry-Waller	retiredj		Barnes Cor	ntracting			
d 2	e filed al Hyg other vent, t	Be C	17. Father's Name (First, Middle, Last)		1 2.1		me (First, Middle, Ma	aiden Surname)				
ylar	should be and Mental s marked of umatic eve	To	Phillip L. Miller	ſ 				Fahey Mille				
Mar	d 2		19a. Informant's Name/Relationship (Linda Nield	Type. Print) sister	19b. Mailing Address (5 913 Lexit	Street and Number or R. ngton Avenu	ural Route Number, IE Cum	City or Town, State, Zip berland N	^{Code)} 1D 21502			
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 □ Paurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Disposition (Name cemetery, crematory or othe unset Memorial P	er place)	Date 2/20/2009	Oc. Location - City or Tov Cumberlar				
Baltii	permit. F Departm Importar any injui		21. Signature of Funeral Service Licer			Address of Facility Carpelli Funeral F						
			23a. Part 1. Enter the disease, or com	glications the cared the dea		Nirginia Avenu of dying, such as cardia			Approximate Interval Between			
	Physician	10	Immediate Cause (Final disease or condition		a red the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a line. Approximation interval B							
	/Medical		resulting in death)	Due to (or as a conse								
	Examiner	je je	Sequentially list conditions,	b. Due to (or as a conse	aquence of: for U	THIP Fracture DAYS						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clasase or hijury that initiated events		decines ei/i. TOL II)	tp Fracture	1 1	7175				
oʻ	e exectan an arrial-tr		resulting in death) Last	Due to (or as a conse	equence of):		OVED BY MEDICAL	EXAMINER				
09289	certificate be executed rding physician and ise as the burial-transit	Medical		d		CERTIFICATION AP	PKOVED BY MEDICAL					
	S di se		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		1/		23d. Date of delive	rv			
Box	law requires that the death ce ias been signed by the attendi 2 should be detached for use	Physician/	in the past 12 months? 1 □Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown					Day Year			
P.0	at the	Phys	9 Unknown Part II. Other significant conditions of		equiting in the underlying cou	una siyan in Part I	23a Did tobs	acco use contribute to th	a cause of death?			
ds,	w requires that the d been signed by the should be detached	d by	PHRONIC DBST	RUCTIVE F	PULMONAK	Py DISFA	100	s 2 □ No 3 ☐ Prob				
CO	w requal speer shoul	lete	CARDIONYO	SPATHY			24a. Was an	24b. Were autop	osy findings available			
of Vital Records,	ω <u> </u>	Completed		1 - 1 - 1 - 1			autopsy perform 1 □ Yes 2	ed? death?	npletion of cause of			
/ital	ıysician: Thı ıis certificate director, pag	Be C	25. Was case referred to medical examiner?				ath (Check only one					
of V		၉	1 X Yes 2□415		ZER/Outpatient 3 ☐ DOA 28b. Time of 28c		T	nce 6 Other (Specify	/)			
on	ding I h. After funer	tion	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 01/29/2009	Unknowh M	c. Injury at Work? 1 □Yes 2 X No	28d. Describe how					
Division	Atten er deal ector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, street, factory, o	office	28f. Location (Stre	eet and Number or Rural	l Route Number,			
Ö	ital or irs afte ral Dir led in	Cert		Ноте			Cumberla					
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical		nysician: To the best of my kininer: On the basis of examinand manner stated.								
	To the within To the Comple	Me	29b. Signature and title of certifier		29c. I	License number	29	d. Date signed (Month, L	Day, Year)			
			8m	Klan	De D	0054	204	2/17/8	2009			
			30. Name and address of person who	completed cause of death (It	em 23a) (Type, Print)	trum H	AN I Anno	HE MD S	len			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature . NI	INMIT CHI	المار ساما	ILL JIN O	11540			
			MAD OF DOOD	A	had the							

09-0	1702	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 07206 Michael Paul Mitchell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No Decedent's Name (First, Middle,Last) 2: Date of Death 3. Time of Death Physician/ Month Day February 27, 2009 **Medical Examiner** 1456 hrs MICHAEL PAUL MITCHELL 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death 806 Coen Road Harford Street 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. Months Hours Director 217-06-4963 M 2 F Yrs 25 06/24/1983 Maryland Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County Yes 2 X No 28a-f show MD Harford Street death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Coen Road 21154 USA 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No White 10 If Yes, Give Year Widowed 4 Divorced Yes 2 X No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry

Laborer

Physicia /Medica xamine

yes 1 and 2 should be filed within 72 h of Health and Mental Hyg.ene.

Pages 1 and 2

Baltimore, MD 21215-0036

Completed

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Ricky A. Mitchell

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32/Registrar's Signature

Ana Rubio MD.

31. Date filed (Month, Day, Year)

College (1-4 or 5+)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

Be	Ricky A. Mitchell	Penny	Ewing
2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
	Penny Kane/Mother	12495 Canning House	Road, Felton, PA 17322
		ace of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
	Dullar 2 / Diemation 3 Removal Iron State	ematory or other place)	/2/2000 1 1 - 73
	4 Ibonation 5 Tother Specify		2/2009 Leola, PA
1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	La C
	C. Kovert tolluson	Harkins Funeral Ho	me, Inc., DElta, PA 17314
	23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
1	Immediate Cause (Final disease a. Asphyxia		Death
	or condition resulting in death) Due to (or as a consequence of):		
	b Hanging		
e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
를	cause. Enter Underlying Cause (Disease or injury that initiated		
Examiner	events resulting in death) Last Due to (or as a consequence of):		
	d		
Physician/Medical	UNPENDED AMENDED		
ĕ	IF FEMALE: 23c. If yes, outcome of pregna	ancv	23d. Date of delivery
Į,	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	nancy Month Day Year
<u> :</u>	Pregnant at time of deal	h 5 Other (Specify)	
ys	1 Yes 2 No 9 Unknown g Unknown		
	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Completed by			1 Yes 2 No 3 Probably 4 Unknown
ĕ			24a. Was an 24b. Were autopsy findings available
జ			autopsy prior to completion of cause of death?
0			1 Yes 2 ✓ No 1 Yes 2 No
BeC	25. Was case referred to medical	26.Place of Death (Check	k only one)
8	examiner? 1 • Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA Other Nursi	ing Home 5 Residence 6 ✔ Other: Scene
2	27. Manner of Death 28a. Date of Injury 2	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
<u></u>	9 Pending	FOUND: 1 Yes 2 ✓ No	Subject found hanging
g	2 Accident Investigation Feb 27, 2009	1430 hrs ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Ę	Suicide Could not be		or Town, State)
edical Certification:	4 Homicide	ly Home	806 Coen Road , Street, MD
a	29a. Certifier 1 Certifying Physician: To the best of my knowledge		
ğ	one) 2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
≗	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

during most of working life. DO NOT use retired)

Construction

18. Mother's Name (First, Middle, Maiden Surname)

Registra

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 28, 2009

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mar 1, 2009 1545 Morgan Thelma /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Aug 26, 1919 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ ¥ "MD 217-10-7336 89 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at Allegany MD Cumberland 1 □¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 423 Pennsylvania Avenue 21502 USA Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Explications. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify: by If Yes, Give Year or Dates: 3 Nidowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry J. Wharton Nora Ellen Rice Wharton 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 384 McHenry Street LaVale MD 2 19a. Informant's Name/Relationship (Type, Print) James Morgan son LaVale MD 21502 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Restlawn Memorial Gardens 3/4/2009 MD LaVale * 4 ☐ Donation ~ 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberla se of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, shock, or heart affure. Immediate Cause (Final **Physician** oronan a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 \ Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 00033280 2,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUPTA, M.D. AME. CUMBERLAND, MD 2150 Gas KONT 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #18, perF. Home, 2/23/09, BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 8:22 P M Charles E. Norris, Jr. 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1005 Edgewater Lane Apt. 401 Worcester Ocean City Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 XM 2 □ F Months Days 214-36-3021 1/16/1939 70 Washington D.C. Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County show d other than "natural", or items 23a or 28a-f shov event, the Medical Exa∴iir at roust be rofiffed at 1 ☐ Yes 2X No Director MD Snow Hill Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 302 West Market St. 21863 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreman Printing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any lipiny or other traumatic event one. Be Lillian Ballard Charles E. Norris, Sr. Lillian Unknown ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Norris / wife 302 West Market St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/21/2009 Frankford, De 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatury f Funeral Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Decubitus Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Lung Cancer Due to (or as a consequence of): of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an this certificate has ral director, page 2 a 1 ☐Yes 2 K No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence (Control Rental 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Division Injury ours after death.

ieral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a XXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d0067227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Race track Rd Berlin, MD BA5+1 Danielle 11107

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 23 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. 16, 2009 **Physician** Marquerite Helene Nielson 7:10 D /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury, Md21804 Salisbury Rehab & Nurs.Center Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months **Funeral** Days 1 □ M 2 🗙 F 92 05/11/1916 514-28-5374 Vermont Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City. Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Machael Experience mast be notified a once. 1 ☐ Yes 2X No Director Maryland Wicomico Hebron 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26242 Quantico Creek Road 21830 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Tes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) public education teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merritt H. Mann, Sr. Lois Stebbins ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13614 S. Sycamore St., Olathe, KS 66062 Merritt Nielson/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mountain View 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5/22/09 Waterville, VT 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OUdisease or condition resulting in death) 70 h die /Medical Due to (or as a consequent of) Examiner s quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performe 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural ours after death.

neral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBINS 200 Civic WILLIAM D. Ave. Salisbury, 31. Date filed (Month, Day, 32. Registrar's Signature State Registra

MARGUERITE

			State of Maryland		artment of Hertificate of E			/ 11	09	07211	0
			Registrar 1. Decedent's Name (First, Middle, Last)		incate of L	- Calli	2. Date of Dea	eg. No.		3. Time of Death	
	Physici /Medic		JoAnne Patricia Norris				Februa	ry ^{Day} 27, 3	2009	2:00 AM	ı
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County	of Death		
	Funeral		44396 Clarks Landing Road 5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthdav)	Hollywo		8. Date of Birth		9. Birthpla	ice (State or Foreig	
	Funeral Director		219-46-7977 1□M 2N F 63	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Mar 15,	^{Year)} 1945	Maryl	y) '_	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Lo	cation				10	d. Inside City Limits	
	Maryl F sho	ţo		ollywo						1 □Yes 2 📉 No	
	th the	Direc	10e. Street and Number	/11 y W O	10f. Zip Code		1	0g. Citizen of W	hat Countr	y?	
	ath wi	eral	44396 Clarks Landing Road	1	20636				SA		_
0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exactive Fourt to traffif of at	Funeral Director	11. Marital Status 1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2. ▼No	l l	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto l	ecify Yes or No- Rican, etc.)		- America c, White, etc		
215-0036	ours a	d by	3 🗓 Widowed 4 □ Divorced If Yes, Give Ye ar or Dates:	1	I∐Yes 2∭XNo	Specify:		Specify:	White	е	
2	"natu	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done do OO NOT use retired)	uring most of working	ng	16b. Kind of Bus	b. Kind of Business/Industry		
717	l withir giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Co-Ow				Auto Part	s Comp	any	
na	be filed tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Surname))		
yiand	d Ment market natic e	_C	James Manning Adams, Sr.			Jean Perie					
Mar	id 2 sh Ith and 27 is r traur		19a. Informant's Name/Relationship (Type. Print) Jason Norris / Son	1	g Address <i>(Street a.</i> Ox 766, HoL				štate, Zip C	Code)	
ē,	is 1 ar		20a. Method of Disposition 20b. Pla		sition (Name of natory or other place			20c. Location - 0	Dity or Tow	n, State	
Ē	Page ment c ant: If ury or			John's	Cemetery	2, 20	09	Hollywood			
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Exacting in must be notifyed any once.		21. Signature of Funeral Service Licenses	7	.O. Box 270		-			Home, P.A.	
П			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						-	Approximate nterval Between	
	Physician		Immediate Cause (Final disease or condition	LA	TERM SO	LKILUSIS				Onset and Death	
	/Medical Examiner		resulting in death) Due (or as a seque								
		jer	Sequentially list conditions, if an area in the cause. Enter Underlying Cause (Disease or injury	ence of							_
	acuted nd transit	Examiner	that initiated events C.								
8/60,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a conseque	ence of):							
	ificate g phys is the l	edical	d			-					_
go	th cert tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy				of delivery		
D	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 Moo 9 □ Unknown 9 □ Unknown		Other (specify)			Mon	th D	ay Year	
ř.	that the		Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause giver	n in Part I.	23e. Did tol	pacco use contri	bute to the	cause of death?	
ecords,	quires en sigr uld be	ed by					1 □ Ye	s 2 54 No :	3 ☐ Proba	bly 4 ☐ Unknown	,
ပ္သ	law re	Completed					24a. Was a			sy findings available	,
<u> </u>	: The icate h	Cod					perforr	ned? de	eath?	⊠No	
VII.	sician certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	D/Outration	Othor	26. Place of Death	3				_
0	ig Phy ter this neral d	\vdash	27. Manner of Death 28a. Date of Injury 2	28b. Time of Injury	28c. Injury Work?	4 Nursing Hon at 2		w injury occurre			
VISION	tendir eath. tor: Af the fur	catic	2 Accident investigation		M 1 □ Y	es 2□No					
<u> </u>	lor At after d Direct	Certification:	determined 28e. Place of Injury - At hombuilding, etc. (Specify)	ne, farm, stre	eet, factory, office	2	t8f. Location (St City or Town	reet and Numbe n, State)	r or Rural I	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours atterdeath. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated	ledge, death	n occurred at the tim restigation, in my op	e, date and place, a inion, death occurre	and due to the c	ause(s) and mar ate and place, a	ner as sta	ted. he cause(s)	
	Fo the within 2 comple	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. License	number	2	9d. Date signed	(Month, D:	ay, Year)	
	0)		Mibut 1 Baver, MD			014168		2 - 2	7-0	9	
	12		30. Name and address of person who completed cause of death (Item 2 28103 Three Notch Rd., Ste 101	23a) (Type, F	echanic	J. Bauer, I	M.D. Md. 21	659			
	Sta Registra		31. Date filed (Month, Day, Year)	ire	W.S	1					
				17							

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Paulette Marie Neat ebruary 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days Year) 1 M 2 XF Hours Yrs. 236-78-5014 Director 59 30, 1949 May Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f showing Wedlest Exprince cust be notified at Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 South Walnut Street Apt#101 21740 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Washington Countu permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Ir. M. any injury or other traumatic event, Ir. M. Dinge. Elementary/Secondary (0-12) College (1-4or 5+) Commission On Aging Elderly Assistance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Alexander Lloyd Evelee Elizabeth Strawderman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 259 Charity Circle Falling Waters, WV 25419 Joseph M. Neat (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March Smithsburg, Maryland Smithsburg Crematory 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licer J.L. Davis Funeral Home MO 14 14 12525 Bradbury Ave. Smithsburg, Maruland 21783 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Immediate Cause (Final disease or condition resulting in death) **Physician** YUS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit WASHIC Division of Vital Records, P.O. Box 68760 $^{\sim}_{i\sigma}$ Due to (or as a consequence of attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 mon 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. **Other significant conditions** co*ntri*buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 12 NOIDS cate has been signated by page 2 should b 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 🗀 🕊 0 1 Inpatient 2 DEN Outpatient 3 □ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) Martha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

MICHAEL

31. Date filed (Month, Day, Year)

FEB 192009

Box 68760.

P.0.

DEFENCE

alendan 441

32. Registrar's Signature

ANNAPOLIS MO21401

State of Maryland / Department of Health and Mental Hygiene 1 9 07213

				Certificate of Death	Reg. No.	01210
			Decedent's Name (First, Middle, Last)	0.	2. Dete of Deeth	3. Time of Death
	Physici Medio/		Avious Lenora	Pinkett	Month Dey Year	
·	Examir		4a Fecility Name (If not institution, give street end number)		Location of Deeth 4c. County of De	
1			4882 Old Route 5	O Vie	enna Dorce	hester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest	birthday) If Under 1 Year If Under 24 Hr		Birthplace (State or Foreign Country)
	Director		216-18-2910 10M 20F 86	Yrs. Months Days Hours Min	- 10733 4	lary/and
	TO .		Usuel Residence of Decedent		1301.6.1,1001/1	141914110
	anylan show		10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
Y	the Mar 28a-f s	ş	MD Dorchester 1	lienna		1 Yes 2 No
\mathcal{C}	vith the Maryla or 28a-f shor be notified at	ē	10e. Street end Number	10f. Zip Code	10g. Citizen of What	Country?
2	th wil	a D	4882 Old Route 5	0 21869	7154	4
0	ter deat	Funeral Director	11. Meritet Status 12. Wes Decedent Ever in U.S.	13. Was Decedent of Hispenic Origin? (If Yes, specify Cuben, Mexican, Pue	Specify Yes or No- 14. Race - Ar	merican Indian,
0	aftar or fte		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No		rto Rican, etc.) Black, W	hite, etc.
02	ours a	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Yeer or Detes:	1 ☐ Yes 2 ☑ No Specify:	Specify:	lock
21215-0020	within 72 hours aftar daath with the Maryland ana. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notitied at	Be Completed	15. Decedent's Education 16	a. Decedent's Usual Occupetion	16b. Kind of Busines	ss/Industry
21	hin .	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of we life. DO NOT use retired)	orking	
21	filed will Hygian ther th	5	77	rocessing Line 4	Vorker Food Pr	ocessina
b	of the A	3e	17. Father's Neme (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sumame)	3
<u>a</u>	Aenta Aenta treed	ည	Isaac Johnson	n Paul	ine Dicker.	SON
Maryland	d 2 should be filed within and Mental Hygiana. 7 Is marked other than traumatic event, the M			9b. Mailing Address (Street and Number or F		
	1 and 2 Haalth a em 27 la		Medford R. Pinkett 8	1016 Hollis St. P	hiladelPhia, Pa	19150
Baltimore,	w = = 0		20a. Method of Disposition 20b. Place	of Disposition (Name of tery, crematory or other place)	Date 20c. Location - City of	or Town, State
Ĕ	Paga Imant c tant: If jury or		TED Burial 2 Cremation 3 CHemoval from State	nna Cemetery	2/24/09 Vienna	MD
=	parmit. Pag Dapartmant Important: I any Injury o		21. Signature of Funeral Service Licensee	22 Name and Address a acility		/41/2
ä	Dapard Import any in	- 2	DO MAR O DAMA	HENRY FUNERAL.	HOME, P.A.	21/1-
		П	Janelle C. Spency	510 Washington	St. Cambridge, 1	ND-21613
			23a. Pa 1. Enter the disease, or complications that caused the Stath. District, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Intervel Between
1	Physician /Medical Examiner		Immediate Cours /Final	1 / //		Onset and Death
			Immediate Cause (Finel disease or condition resulting in death) a. Unclude:		10 mm	
		<u>_</u>	Due to (or es	a consequence of);		
	nsit led	Examiner	- Coronny	True Diser	50	1040
	artificata be axecuted ling physician and is as the burial-transit	xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence(of)	1	
68760,	icata be a physician s tha buria		cause. Enter Underlying Cause (Disease or injury	is feart fail	ure	515
387	cata phys tha	edicai	that initiated events resulting in death) Last	consequence of):		•
×	ding p	3	d			
Bo	aath cartif attanding for usa a	Physician				
0	tha thad	ysic	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobecco use contribu	te to the cause of death?
<u>α</u>	that tha daath carti nad by tha attanding a datachad for usa a	£		4	1 Yes 2 No 3 Probably 4 Unknown	
Ś	D G	þ				
5	r raquiras bean sign should ba	Completed			24a. Was en autopsy performed?	Were autopsy findings aveilable prior to
ec	S S ₹	힏				completion of cause of deeth?
	Tha is cata ha paga	Ñ			1 Yes 2 No	1 ☐ Yes 2 No
ita	ysician: The		25. Was case referred to medical examiner?	26. Place of De	ath (Check only one)	
of Vital Records,	2 00	2	1 ☐ Yes 2 ☐ No Hospitat 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing I	Home Pasidence 6 □Other (Sp	pecify)
	ng Pl	ä	27. Manner of Deeth 1254 atural 5 ☐ Pending (Month, Day Year) 28b	Time of 28c. Injury at Work?	28d. Describe how injury occurred	Ti
<u>.</u>	Attending r daath. ector: Atta by tha funa	äţ	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	ar de	<u></u>	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or I City or Town, Stete)	Rurel Route Number,
	To the Hospital or Attending Phy within 24 hours aftar daath. To the Funeral Director: Aftar thi complataly filled in by tha funaral	Certification:	55ag, 56 (Option))			
	To the Hospital within 24 hours fo the Funeral complataly filled	edical	29a. Certifier (Check only only) (Check only only)	je, death occurred at the time, date and place	a, and due to the cause(s) and manner	as stated.
	the H iin 24 ihe Fi		and manner stated.		arred at the time, date and place, and di	re to the cause(s)
	To T	≥	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
			1 Mittalden	D2638	8 Pel 20	,2009
_	10		30. Neme en ddrew of person who completed cause of death (Item 23e)	(Type, Print)	1 1 1 1	. 0
	0		Mecine / Freddan AS	302 collas	Auc Hurlook	Md 21643
	Stat	te	31. Date filed (Month, Day, Year) 32. Registrer's Signature	1		
	Registra	ar	TED ZO ZIE	branked		1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2009 February 15 10:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worceste Nursing erlin 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1.25 M 2□ F Months Days Hours 68 Director 219 34-9240 113 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in closed to a state of any injury or other traumatic event, it is in closed. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director MA 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married urnell, Louis Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Blac 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဂ္ urne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD imoth 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bernie Smith tuneral Home 23a, Part 1, Enter the disease, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 ☐ Yes After this certificate has been s funeral director, page 2 should it Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 21 25. Was case referred to medica Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospita to within 24 hours after death.

To the Funeral Director: At analytic in the funeral Director At analytic in the fur Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

VOHEA 614 EASTERN

SHOKE 32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD.

D 63199

29d. Date signed (Month, Day, Year)

7109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, 2009 **Physician** Month Brenda May Pilkerton 4:50 AM February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 22834 Maddox Road Bushwood If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖺 F 216-80-4064 51 Maryland Director February 12, 1958 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Evantines must be notified at Bushwood 1 ☐ Yes 2X No Director Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once. 22834 Maddox Road 20618 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1∐Yes 2X∑No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Medical Record Coder Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Matthew Oliver, Sr. Helen Virginia Welty ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22834 Maddox Road Stanley Patrick Pilkerton / Husband Bushwood, Maryland 20618 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State February 28 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 ture of Funeral Service bicens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death Immediate Cause (Final disease or condition resulting in death) Dye to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Ly FARIST CLAPES TO PHARPIN, EMB 39 EARS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ALIGNANT ME Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 NO 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 √0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 015027 Cocki 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Roache, M.D. 28130 Three Notch Road Mechanicsville, MD 20659 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 25 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009

			For State Registrar	State of Marylan		rtificate of			g. No.	9 0/216
	Physicia		1. Decedent's Name (First, Middle, La: Christopher Antl	·				2. Date of Death Month February	Day Year	3. Time of Death 2:28 p M
1000	/Medic Examin		4a. Facility Name (If not institution, giv Suburban Hospita	e street and number)			r Location of Death nesda		4c. County of De	
	Funeral Director		5. Social Security Number 212-15-0892 6. S	ex 7. Age (In yrs. 36	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 11,	Year) 9. B	irthplace (State or Foreign Country) Virginia
	r 28a-f show	Director	Usual Residence of Decedent	ontgomery 10c. Cit	ty, Town or Lo	sington 10f. Zip Code		10	g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2★★o Country?
	ath with s 23a o nust be		4316 Puller Driv				20895		USA	
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heatih and Merhal Hygiene and the file of 21 s marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Examiner must be notified at	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🛣 No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
	"natur		15. Decedent's Ed (Specify only highest gra	ide completed)	i (Give	edent's Usual Occup kind of work done DO NOT use retired	durina most of worki	ng 1	6b. Kind of Busines	s/Industry
	d withii giene. er than		Elementary/Secondary (0-12)	College (1-4or 5+)		Manageme	í.		Restaur	ant
	be file ntal Hy ed othe event,		17. Father's Name (First, Middle, Last,				18. Mother's Name	(First, Middle, M.	aiden Surname)	
	should nd Mer marke imatic		Arthur R. Point 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	Judith and Number or Rura	A. Saur		Zip Code)
	and 2: ealth a n 27 Is er trau		Arthur R. Pointer	:/Father	<u> </u>		ler Drive	1		
	permit. Pages 1. Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	y) Ga	te of	osition (Name of matory or other place Heaven Ce	metery	b. 26, s		ing,Maryland
Ra	permii Depar Impor any ir once,		21. Signature of Funeral Service Licer	nsee	2	Francis J 500 Unive	ss of Eachlity • Collins ersity Blv	Funeral	Home Ind	:. ing,MD 20901
and a	hysician /Medical Examiner		23a. Part 1. En r the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. a. The time and Due to (or as a consequence)	h. Do not en	ter the mode of dyir				Approximate Interval Between Onset and Death 5 years
E		je.	Sequentially list conditions, if any, leading to immediate	uence of):						
	rtificate be executed ng physician and as the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)							
68760,	cate be ohysicia the bur	Medical	•	d						
rision of Vital Records, P.O. Box	death ce e attendi d for use	Medical Certification: To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	Sy		23d. Date of d Month	elivery Day Year
	w requires that the s been signed by th should be detache			at conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions of the conditions contribute to the conditions contributing to death but not resulting in the underlying cause given in Part I.					to the cause of death?	
	aw Is t							24a. Was an autopsy perform	prior to	
	cian: pertifica ector, p		25. Was case referred to medical examiner?	Hospital:		Low	26. Place of Death			.5 20110
	ding Phy n. After this funeral d		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury						
	al or Atteness after death		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)							Rural Route Number,
	To the Hospital or , within 24 hours after the Funeral Dire completely filled in the completely filled in the completely filled in the first the filled in the completely filled in the			nysician: To the best of my knowniner: On the basis of examination and manner stated.						
	To the within 2 to the comple		29b. Signature and title of certifier	< 508	~	29c. Licens	se number D43083		d. Date signed (Mo	
	5		30. Name and address of person who George A. Sotos,				ve, #300,		February le, MD 20	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 0 200	2. Registrar's Signa			<u>`</u> _			

	1	State of Maryland / Department of Health and Months - For State - Registrar Certificate of Death	Reg	g. NZUU9 U/ZI/
Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last) TOSE MANUEL PALACIOS a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Death Month O2	Day Year 15 2009 14:54 P M 4c. County of Death
Funeral Director	5	Months Days Hours Min.	8. Date of Birth (Month, Day, March 18	Year) 9. Birthplace (State or Foreign Country) 8, 1980 Nicaragua
ne Maryland Ba-f show ptified at	-	Maryland Montgomery Silver Spring		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
fire death with the Mar ritems 23a or 28a-f st iner must be notified	B	10e. Street and Number 11101 Georgia Avenue, Apt. 248 20902		g. Citizen of What Country? USA
33.	<u>~</u>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 1 ☐ Xeyes 2 ☐ No Specify: Nica:	raguan	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 d within 72 hours aft giene. er than "natural", or it the Medical Exami, the Medical Exami	nataldillon	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finance Director		6b. Kind of Business/Industry Non-Profit Organizatio
and d be filed ental Hy ced other c event,	מ	17. Father's Name (First, Middle, Last) Efrain Palacios Luisa	(First, Middle, Ma	aiden Surname)
Maryland Id 2 should be file the and Mental Hy 27 Is marked other traumatic event		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural	I Route Number,	City or Town, State, Zip Code) t D301, Laurel, MD 2072
Baltimore, I bermit. Pages 1 and Department of Heal Mportant: If Item 2 any injury or other	1	20a. Method of Disposition 1 \(\Delta \) Burial 2 \(\Delta \) Cremation 3 \(\Delta \) Removal from State 4 \(\Delta \) Donation 5 \(\Delta \) (Specify) 4 \(\Delta \) Donation 5 \(\Delta \) (Specify) 4 \(\Delta \) Donation 5 \(\Delta \) (Specify)	eb. 21	Oc. Location - City or Town, State
Physician /Medical Examiner		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins I 500 University Blvd 23a. P. 11. Enter the disease, or complications the Journal Service List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a		lver Spring, MD 20901-
76(IMEGICAL EX	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the asst 12 months? 1		23d. Date of delivery Month Day Year
P.O. In that the deaded by the adetached for the deaded for the de	riiysic	4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23e. Did toba	acco use contribute to the cause of death?
aquires t	2		1 ☐ Yes	3 Probably 4 Unknown
Attending Physician: The law requires that the death certifica releath. setor: After this certificate has been signed by the attending property the funeral director, page 2 should be detached for use as the following property of the Completed by Physician Medicalization.	e completed	25. Was case referred to medical 26. Place of Death	24a. Was an autopsy performed 1 Tyes 2	prior to completion of cause of death? No 1 Yes 2 No
Of Vita		examiner? 1 Yes 2 No	ne 5 Resider	nce 6 Other (Specify)
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be deathfacetion. To Be Completed by	Certification: 10	1 Matural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation	8d. Describe how 8f. Location (Stre City or Town,	eet and Number or Rural Route Number,
E a s E	Medical Ce	29a. Certifier (Check only one)		
To the within 1		200 Liganos pumbor	29	d. Date signed (Month, Day, Year) 2 - 16 - 2009
State Registrar		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 19 2009	alTimos	es.m) 21201

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician JAMES** E. PRICE, SR. FEBRUARY 28 2009 9:20p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10435 Big Stone Rd. Millington Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 216-09-0003 96 1912 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2K No ral", or Items 23a or 28a-f sh Examiner must be notified MD Kent Millington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10435 Big Stone Rd. 21651 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 10 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self-employed Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Builder 4 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event gones. Be Seth Aldridge Price Ola Everett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lex P. Price (son) 10551 Big Stone Rd. Millington, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Asbury Cemetery 3/4/09 Millington, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Listing Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons **Examiner** sician and burial-tran 8

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely filled in by the f

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate the conditions of the con	b. Due to (or as a niece c. Due to (or as a consecution)	vr. 1	, the	ive	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. if yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 □Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed' 1 Yes 2	
25. Was case referred to medical examiner?				eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 D	OA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of eath 1 Naturai 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, facto	ry, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 CertifyIng Pl (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29	c. License number	29d. [Date signed (Month, Day, Year)

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State Registrar

DK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael Gasparovich, D.O.

31. Date filed (Month, Day, Year)

#0067888 3/3/09

119 C. North Main St. Galena, MD. 21635

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28a-f per me, g889,03,06,09dhb Reg. No. 1 - State Registrar Amend Items 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Natthew /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MAN 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country) Oct. 25, 1966 Maryland If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Min. 42 Yrs. Director 208-60-5747 Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Garrett Grantsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a USA 21536 1880 Gaswell Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ò 1 ☐Yes 2 🕱 No 2 If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 😾 Divorced White "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Timber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Mildred Durst Harry Kenneth Pope ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains 1440 Valley Vista Lane, Forest, VA Mildred P. Schetrompf/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 13, 2009 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 21. Signature of Funeral Service Liq 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SELF INPLICTED UNSHOT WOUND disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury

Found Day, Year)
02/08/2009 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Found:
10:11 p. 5 ☐ Pending investigation 1 Natural Subject shot self. 1 ☐ Yes 2 🐴 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1195 Gaswell Rd., determined 4 Homicide Home Grantsville, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 30. Name and address of person

Registrar
DHMH 17 Rev 1/2001

State

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32.

Registrar's Signatur

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			For State	State of Maryland				l Mental Hy	/ 11	09	072	220
	*		Registrar 1. Decedent's Name (First, Middle, Last)		Ceri	tificate o	Deam	2. Date of D	Reg. No.		3. Time of	
	Physicia /Medic			, QUINN				FEB	Day 15	Year 2009	1 4:05	5 AM
J	Examin		4a. Facility Name (If not institution, give str University of Maryla		Lav		or Location of De		4c. County		1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Yes	ar If Under 24 H	rs. 8 Date of Bi	rth	9. Birth	nplace (State o	or Foreign
	Director		213-20-2007	⁴ ¾ □ F	7 Yrs.	Months Day	s Hours Mi	Feb 1	2 1932	N.	Caro1	ina
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		Town or Loc						10d. Inside Ci	ity Limits
	e Mar 8a-f sh rtified	Director	Maryland Anne Aru	ndel Pa	sader			_	4- 000		1 🗌 Yes	2 X No
	with the		10e. Street and Number 8343 Catherine A	ve		10f. Zip Code	122		10g. Citizen of V		untry?	
	death	Funeral		. Was Decedent Ever in U.S.	13. W		f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)			rican Indian,	
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		□Yes 2□XN				y: B1	ack	
215-0036	72 hour natural lical Ex	ted t	15. Decedent's Educa	tion	16a. Decede	ent's Usual Occ	cupation the during most of v	vorkina	16b. Kind of B			
121	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ONOT use ret Custod	ne during most of v red)		Anne A			
2	should be filed v nd Mental Hygie marked other t ımatic event, th	Be Co	12th 17. Father's Name (First, Middle, Last)	0		<u>us tou</u>		lame (First, Middle			Euuca	CIOII
ylar	should be and Menta s marked umatic ev	To E	Moses Lynch					ce Redw		4		
Maryland 2	2 a is		19a. Informant's Name/Relationship (Type Marcia Pryor(Dau	, i	`	•	et and Number or Frederi		ber, City or Town, Baltin			2122
	ss 1 and of Health item 27 rother to		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Rei	4VFaPracen	oe di Dispos Hetery, crem	tion Wante of atory or other p	onal	Date	20c. Location	- City or T	Town, State	
altimore,	t. Pages tment of I tant: If ite		4 Donation 5 ☐ Other (Specify)	1.1		ial Pa		21-09	Laurel	200	id .	
g	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licensee	100883			t St. Ai		-		01	
F	*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the death.	Do not ente	er the mode of o	lying, such as card	liac or respiratory	arrest,		Approximate Interval Bet Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			+ fa	ilure			- 3	2 We	
	Examiner			Due to (or as a consequent of the cardio	nce of):	nfarc	tion				2 We	eks
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due tJ (or as a conseque								
	execute n and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):							
8760,	ate be executed hysician and the burial-transit	dical	d.			-·-						
39 X	leath certifics attending pl	/Med	IF FEMALE: 23	c. If yes, outcome pf pregnance	cy				23d Da	ate of deli	verv	
Division or Vital Records, P.O. Box	death e atten d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 🗆	Ectopic pregna Other (specify)			l l	onth		Year
о <u>.</u>	nat the de d by the a etached	Phys	9 ☐ Unknown Part II. Other significant conditions conti	The second second	ing in the un	derlying cause	given in Part I	23e. Did	tobacco use con	tribute to	the cause of	death?
ĠS,	w requires that been signed b should be deta	d by	acute renal	failure			g	_ 1□	Yes 2⊠No	3 🗆 Pro	obably 4 🗍	Unknown
eco	law rec as beel 2 shou	Completed	cholecystitis					24a. Wa	s an 24b.	Were au	topsy findings completion of c	available cause of
m m	:: The cate h							per 1⊡ Yes	formed? 2 3 No	death? 1 ☐ Yes		
Z K	/sician s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☑ Inpatient 2 ☐ EF	R/Outpatient	t 3 DOA	Othor:	Death (Check only g Home 5 ☐ Rea		ner (Spec	cifv)	
100	ng Phy tter thi ineral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of Injury	V	njury at Vork?		how injury occur			
Sio	Vttendi death. ctor: A y the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hom	ne, farm, stre		Yes 2 No	28f. Location	(Street and Numi	ber or Ru	ıral Route Nur	nber,
2	tal or / s after al Dire ed in b	Certification:	4 Homicide	building, etc. (Specify)				City or T	own, State)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Medical		cian: To the best of my knowler: On the basis of examination and manner stated.								s)
	To the within 2	Med	29b. Signature and title of certifier	A		29c. Lice	ense number		29d. Date signe			
	/ ()) yue	el MiD.			472507	ł	Feb	15 7	2009	
	JOH		30. Name and address of person who con Janell M. Alde	ipleted cause of death (Item 2	23a) (Type, I	Print)	Baltim	ore MC	21201			
18	Sta		31. Date filed (Month, Day, Year) FEB 1 9 200	ppleted cause of death (item 2 201, 22 S. G. S.	1	. 4.1	- A A - (1144)	<u></u>				
	Regist	rar	I LD I 3 200	s comment of	· 1490	were						

DHMH 17 Rev 1/2001

			4 127.	epartment of Health and l Dertificate of Death	Mental Hygier	ne No.2009 07221
			1. Decedent's Name (First, Middle, Last)	- Death	2. Date of Death	3. Time of Death
	Physici /Medi		HARRY J. QUINTANA			Oay Year 8:55 A M
March St.	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
uth			WASHINGTON ADVENTIST HOSPITAL	TAKOMA PARK		MONTGOMERY
	Funeral	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birth.	Months Days Hours Min	(Month, Day, Yea	
	Director		Usual Residence of Decedent		JUNE 7, 19	938 PUERTO RICO
	ylanc how		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	e Mar 3a-f s	cto	MD. PRINCE GEORGES	HYATTSVILLE		1.□Yes 2□No
	iff the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	s 23a	eral	4922 LaSALLE RD.	20782		U.S.A.
	item item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ▼□ Ves 2 □ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, it a "vedical Evanfrar must be restlind at	þ	3 Widowed 4 Divorced If Yes, Give 1955—	1X□Yes 2□No Specify:	TO RICAN	Specify: HISPANIC
5-0036	72 hor	Completed	15. Decedent's Education 16a. D	ecedent's Usual Occupation	16b.	Kind of Business/Industry
2	ithin 7 ne. san "r	nple	(Specify only highest grade completed) (CElementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work ife. DO NOT use retired)	king	
2	ed wi		3	ARCHITECT		H.U.D.
Maryland	be od e	Be	17. Father's Name (First, Middle, Last)	UNK . 18. Mother's Nan	ne (First, Middle, Maide	en Surname) UNK.
Š	d 2 should th and Mer 7 is marke treumetic	၉		Anilian Address (Chart and Number of Ch	TRINA	T 0: - T 0: -
	d 2 th a 7 is			failing Address (Street and Number or Ru		, , , , , ,
altimore,	- T 0 -		20a. Method of Disposition 20b. Place of D	00 N. BAY SHORE DR. isposition (Name of		Location - City or Town, State
Ë	Pages nent of int: If it		Burial 2X1 Cremation 3 Li Removal from State	crematory or other place) ERS CREMATORY 2-20	_2009 P	IVERDALE, MD.
aĦ	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility CHAMBERS FUNERAL H		
10	8258		MM Chambura M00091	5801 CLEVELAND AVE	., RIVERDA	LE, MD. 20737
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on an in line.			Approximate Interval Between
and,	Physician		Immediate Cause (Final disease or condition assets or condition	i neumo	no	Onset and Death
- Ph	/Medical Examiner		resulting in death) Due to (or as a onsequence of)			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
)	uted d ansit	Examiner	cause. Enter Uncerlying Cause (Disease or injury that initiated events C.			
'n	be executed ician and burial-transit	Еха	resulting in death) Last			
8/6U	ficate be executed physician and s the burial-transit	edical	d			
٥	certifica nding plase as t		IF FEMALE:			
X Q Q	death certific ie attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy	1	23d. Date of delivery Month Day Year
	he de	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day real
٠.	that the by detack		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecords,	n sign	d by	Cerebrovanal of H	ceidata	1 ☐ Yes	
ဝ္ပ	s bee	Completed	E. I Slang Ro	of frule	24a. Was an	24b. Were autopsy findings available
Ä	te ha:	E O	that State Color	4 (000	autopsy performed?	prior to completion of cause of death?
VITAI	rtifica rtor, p	O	25. Was case referred to medical	26. Place of Deal	1 ☐ Yes 2★ N h (Check only one)	lo 1 □Yes 2 □No
> i	nysic his ce I direc	70 B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Others	ome 5 Residence	6 ☐ Other (Specify)
	ng P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inju	e of 28c. Injury at	28d. Describe how inju	
VISION	tend leath. tor: / the fu	cati	2 Accident investigation	M 1 □Yes 2 □No		
<u> </u>	or All	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	spiral ours neral filled		29a. Certifier Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the cause	(a) and manner as stated
	or the fospital or Artending Priystician: The law requires that the of the thin 24 hours effer death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)
1	withir comp	ž	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	IVA		I Down Digt	174366		7-16-07
			30. Name and address of person who completed cause of death (Irem 23a) (Ty	De, Print) DR . DPINDER SI	My H, M.D.	MD 22)10
			14 500, GH CLAVI +	CX (2, 104 C	1200,6	1712 00110
	Stat Registra		31. Date filed (Month, Day, Year) FFR 2 0 2009 37. Registrar's Signature	MILI		

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

		For	1 1000	State	of Marylan						-	- 4	2000	07000
		State Registrar				Ce	rtificat	e of L	Death			Reg. No	2009	
Physicia	an	1. Decedent's Name									2. Date of De Month	Day		
/Medic	al	Marjorie 4a. Facility Name (/		Rider	imber)		4h City	Town or	Location		Februai	-	, 2009 County of Dea	
Examin	er	ManorCar		give street and no	iniber)		Potor		Location	or Death			ntgome	
Funeral		5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year_	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		9. Bi	rthplace (State or Foreign country)
Director		511-32-6	751	1 □ M 2 💢 F	(97 Yrs.	Months	Days	Hours	IVIII1.	Jun 18,	191	1 0k	lahoma
and w		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
f sho	힏			4										1 □Yes 2 XNo
r 28a	Director	MD 10e. Street and Nur	<u>Montgo</u>	mery	ROCK	cville	10f. Zip	Code				10g. Citiz	zen of What C	country?
th with	al D	10916 Wa	xwood C	ourt			208	5 2				USA		
r deal	Funeral	11. Marital Status		12. Was Dec	edent Ever in U. orces?	.S. 13.	Was Deced	dent of Hi cify Cuba	spanic Or n, M exica	rigin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Whi	
s afte	by F	1 ☐ Never Marri 3 🖁 Widowed		ed 1 □ Yes If Yes, G Year or D	ive		1 □Yes	2 X No	Specify	r:			Specify:	:
2 hour	ted	3 ZZ Widowed	15. Decedent			16a. Dece	dent's Usua	al Occupa	ation			16b. Kir	WL1.	ite s/Industry
hin 72 e. an "na Media	Completed	(Special Special Speci		t grade completed) College ((Give	kind of wo DO NOT us	rk done d se retired	luring mos)	st of worki	ing			
ed wit ygien rer th	င္ပ	12				Medi	cal A	ssist			/E: - / 10: 1 !!		thcare	
be fill ad oth even	B	17. Father's Name								ers Name	e (First, Middle Izox	, Maiden	surname)	
hould id Me marke	ပ္	Charles				19h Maili	na Address	(Street a			al Route Numb	er City o	Town State	Zin Code)
od 2 s of the and 2 s 27 is read		Bruce Ri									ckville			p
s 1 ar		20a. Method of Dis			20b. F	Place of Disponentery, cre	osition (Nar matory or o	ne of ther place	e) !	[Date	20c. Lo	cation - City o	r Town, State
Page nent c			MCremation 5 □Other <i>(Sp</i>	3 □Removal from ec <i>ify)</i>		Arund	el Cre	emato	ory				ton, M	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Marical Evanting and the natified in once.		21. Signature of Fu	uneral Service L	icensee ///		Ĝ	2. Name ar	d Addres	s of Facili	natio	n Servi	L c e	P.O. B	ox 784
⊈ 0 = @ 0		Here	ly I.	Halt	MO12	251 B	everl	7 T.	Heck	crott	e PA	_Cla	rksvil	le, MD 21029
			art failure. List o	only one cause on	each line.			ie or ayın	g, sucn as	s cardiac (or respiratory a	irrest,		Approximate interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)	on		iorgan l		<u>e</u>							months
Examiner				b. Seps:		juence or).								weeks
D +	ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate erlying		(or as e conseq	uence of):								
ecuter and transi	Examiner	Cause (Disease or that initiated events resulting in death)	injury s	V	et Infection							weeks		
te be executed ysician and ie burial-transit	cal E	resulting in death) Last Due to (or as a consequence of):												
				d										
n certii anding use a	Physician/Med	iF FEMALE: 23b. Was deceden	it pregnant		tcome of pregn		- · ·					2	23d. Date of de	elivery
death	sicia	in the past 12 1 □Yes 2 [birth 2 ☐ Feta gnant et time of a		☐ Ectopic p ☐ Other (sp		/ 				Month	Day Year
that the de ned by the detached	Phys	9 Unknown					and a state of a second		n in Dort		220 Did	tobacca	eo contributo	to the cause of death?
signer	۵	Part II. Other signit		ns contributing to t	eath but not res	culting in the t	inderlying d	ause give	en in Pari	1.				Probably 4 Unknown
w requires to be a signal should be a	eted			<u>_</u>					.:		24a. Was			autopsy findings available
he law e has ge 2 s	Completed	Osteopor	0515						\$ ₄₀		auto perfe	psy ormed?	prior to death?	completion of cause of
an: Tl tificate tor, pa	ø	25. Was case refer	rred to medicel						26. Plec	e of Deat	1 ☐ Yes		1 ∐ Ye	s 2 No
Physician: The la r this certificate ha ral director, page 2	O B	examiner? 1∐Yes 2∑] No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 D	Othe			me 5 ☐ Res		☐Other (Sp	ecify)
ding Ph h. After th funeral	L:uo	27. Manner of Deat	th 5 🗌 Pending	28a. Date (Mo)	of Injury oth, Day, Year)	28b. Time of Injury		28c. Injury Work	:?		28d. Describe	how injury	occurred	
tendi leath. tor: A	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ation			M		Yes 2		Opt Location	(Ctract or	d Mirmhor or I	Burnt Boute Mumber
or Al after o Direc	Certification: To	4 ☐ Homicide	determi	nod Zoe. Flac	e of Injury - At h ling, etc. (Speci	ome, tarm, si	reet, factor	у, опісе			City or To	wn, State	i Number or r	Rural Route Number,
spital		29a. Certifier		g Physician: To th										
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending phy the Funeral Director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	edical	(Check only one)	2∐ Medical I	Examiner: On the and mar	basis of examination	ation and/or i	nvestigation	n, in my o	pinion, de	eath occur	red at the time	, date and	place, and du	ue to the cause(s)
To the com	Σ	29b. Signature and	title of certifier	0			29	c. License	e number					nth, Day, Year)
6-		* /	Ttu	Qr'				710	160	7.		2.	20.0	1
EG		30. Name and add			ise of death (Iter 810 Dari			d #20	02 0	laith	ersburg	a. MD	20878	
Sta	te	31. Date filed (Mor	nth, Day Year)	4 0 3 32.	Registrar's Signa	ature	iwa	4 712	02 (CLODGE	o,		
Registr		31. Date filed (Mor	FER 2	4 2009	Leneur	B. ,	back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	•	Department of F Certificate of	Death	Reg.		9 07223
	Physic	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	RUSSELL RAMEY 4a. Facility Name (If not institution, give street and number)		# 00 T	r Location of Death	FEBRURARY	144 2000	•
	Funeral Director	ier	JOHNS HOPKINS BAYVIEW ME 5. Social Security Number 6. Sex 7. 12M 2 F 7. 12M	EDICAL CEN Age (In yrs. last birt	NTER BALT thday) if Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Dea	thplace (State or Foreign ountry)
	farylar f show	5	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 → Yes 2 → No
	r 28a-1	Director	10e. Street and Number	Bow	10f. Zip Code		10g.	Citizen of What Co	
	ath with 23a o		10103 GREENSPIR	way	207	21		USA	,
920	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm Incitied at the profiled	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ Yes 2 □ If Yes, Give Year or Dates	s? ⊋ No	13. Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur wadicel	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o)	r 5+)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired METRO & BO	during most of workin d)	9	. Kind of Business/	
1d 2	filed Il Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		101/201/00	18. Mother's Name		den Surname)	SIC
ylar	should be nd Menta marked imatic ev	To B	George C RAMCY			Bernic	E STA	Nicy	
Mar	d 2 s th an 7 ls trau		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street		Route Number, Ci	ty or Town, State, 2	Zip Code)
re,	s 1 and 2 of Health a ltem 27 Is		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place			CIE Md. Location - City or	20721 Town, State
imo	Pages ment of tant; If Its jury or o		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		vin Community		-09 S	refland v	nd.
Balt	permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other Once.	J. I.	21. Signature of Funeral Service Licensee	il		of Facility se of white	ع در مرد		7 1) .C.Zoon
1	Physician	8 1	23a. Pan 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	line.	ot enter the mode of dyin	•	respiratory arrest,		Approximate Interval Between Onset and Death DAY S
1	/Medical Examiner		SEPS	as a consequence o	f):				2 WEEKS
	ted sit	Examiner	cause. Enter Underlying	is a consequence of					2 1 . 190 00 1 . 0
oʻ	rificate be executed og physician and as the burial-transit	Exar	that initiated events	ROPENIA is a consequence of					2 WEEKS
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9	8 5 =	dica	d. CHRON	IC LYMPT	HOCYTIC LY	EUREMIA	2		
o.		ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth	e of pregnancy 2 Fetal death	3 Ectopic pregnancy			23d. Date of deli Month	
P. 0.	res that the death cer signed by the attendin be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant	e of pregnancy 2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y	23e. Did tobacc	Month to use contribute to	ivery
al Records, P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	e of pregnancy 2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y	23e. Did tobacc	Month o use contribute to 2 No 3 Pro 24b. Were au prior to c death?	very Day Year the cause of death?
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of Vital Records, P.O.	nysician: The law requires that the death cer his certificate has been signed by the attendin I director, page 2 should be detached for use	Certification: To Be Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tient 2 ER/Outplay, Year) 28b. Tinglay, Year)	3 Ectopic pregnancy 5 Other (specify) the underlying cause give patient 3 DOA Other me of jury 28c. Injury Work 1 Norm m, street, factory, office	26. Place of Death ar: 4 \sum \text{Nursing Hom} vat cress 2 \sum \text{No} 28	23e. Did tobacc 1 Yes 24a. Was an autopsy performed; 1 Yes 2 (Check only one) e 5 Residence 3d. Describe how in 3f. Location (Street City or Town, Stand due to the cause	Month o use contribute to 2 No 3 Pro 24b. Were au prior to a death? 1 Yes 6 Other (Special of the control	the cause of death? babably 4 Unknown topsy findings available ompletion of cause of 2 No stated
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		For State Registrar	State of Mar	ryland /	Department <i>Certificate</i>				giene Reg. No. 2 (009	07224
Physicia /Medica		1. Decedent's Name (First, Middle, Last	e E	Rus	SE 11			2. Date of Dea Month	/3	Year 2w7	3. Time of Death
Examine Funeral Director	r	4a. Facility Name (If not institution, give	ershill	Call (In yrs. last b	rthday) If Under 1	Year If Und Days Hour	P(1~	3. Date of Birtl Month, Day	mo	9. Birthp Coun	lace (State or Fdreign try) 5h. DC
e Maryland Ba-f show	ctor	10a. State 10b. County MD Montge		10c. City, Tov	on or Location Gaither	sburg				10	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
th with the 23a or 2	Funeral Director	10e. Street and Number 4920 Riggs Ro	ad		10f. Zip 0	2088	2		10g. Citizen of U . S		iry?
330 Irs a	2	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Year or Dates:		13. Was Decede If Yes, specif			ify Yes or No- ican, etc.)		ce - Americack, White, e	etc.
vithin	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation e co <i>mpleted)</i> College (1-4or 5+)		i. Decedent's Usual (Give kind of work life, DO NOT use	done during m retired)	nost of working		16b. Kind of E		ustry
ryland 2 hould be filed and Mental Hygis marked other matic event, II	e R	17. Father's Name (First, Middle, Last) William Copel	and		Housek	18. Mo	,	First, Middle,	Maiden Surna	ome _{me)}	
Maryla d 2 should th and Men T Is marke traumatic	<u> </u>	19a. Informant's Name/Relationship (Ty	rpe. Print)	1	o. Mailing Address (Street and Nur	mber or Rural	Route Numbe	r, City or Town		
Baltimore, Maryland 2 Permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, In once.		David A. Russe. 20a. Method of Disposition 1 Paurial 2 Cremation 3 F 4 Dojlation 5 Other (Specify) 21. Stop to e of Funeral String Logs.	Removal from State	20b. Place o		e of ler place) 'en CeI Address of Fac	n 2/24	1/09 DWDEN	20c. Location Silv FUNER	-City or To er Sr AL H	
Physician // // // // // // // // // // // // //		23a. Part 1. Enter the disease, or comples shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	y a	not enter the mode		as cardiac or				Approximate Interval Between Onset and Death
ate be executed the system and burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Extra Uniterlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or a) Due to (or a	consequence	of):						
BOX 6 sath certifi	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal deat	n 3 ☐ Ectopic pre 5 ☐ Other (spe					ate of delive onth	ry Day Y ear
we requires that	2	Part II. Other significant conditions con	ntributing to death but	not resulting	n the underlying cau	use given in Par	rt I.				e cause of death? ably 4 Unknown
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On of VIta	o De	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/O	utpatient 3 DOA	Other		Check only on e 5 ☐ Reside	ence 6 ⊡Ot	her (Specify	·)
the the	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day,) 28e. Place of Injury building, etc.	Year) / - At home, fa	Time of 28 Injury M	c. Injury at Work? 1 Yes 2	□No	f. Location (S	treet and Num		Route Number,
		29a. Certifier 1/C Certifying Phy.	sician: To the best of ner: On the basis of e	mv knowledo	e, death occurred a	t the time, date	and place, ar	City or Town	cause(s) and m	nanner as st	ated.
To the Howithin 24 To the Fr	Medical	one) 29b. Signature and title of certifier	and manner state	ed		License numbe			9d. Date signe		
5		I sime		ND		653c	1		2/13	109	
		30. Name and address of person who co Farzana Ajmal,	M.D. 322	27 Be		ad, Si	ilver	Sprin	g, MD	2090	16
State Registra		31. Date filed (Month, Day, Year) FFR 2 0 200	32. Registrar's	s Sinnatura	pares.	-					

State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Kenneth Raymond Runyan 23, 7:49 p.m /Medical February 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 22232 Monterey Place Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Davs Hours Min. Director 325-30-1097 71 2/28/1937 Illinois Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar 28a-f show traumatic event, the Mictigal Expression regist be notified at Directo 1 ☐ Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 22232 Monterey Place 20650 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: or items 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural" White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 6 Electrical Engineer Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Raymond Roland Runyan Millie Agnes Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a fitem 27 is r other train Gloria A. Runyan/Wife 22232 Monterey_Place, Leonardtown, MD 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 02/25/2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons 22295 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) acute myeloid leukemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) s been signed by the should be detached 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s 24a. Was an autopsy certificate 2 🛂 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.
neral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) 25500 Point Lookout Rd Or. Mukhtar Hassan Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar red % 6 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Rinaldi Bostic Feb. 14, 2009 7:15a M Iris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12506 Buckley Drive Montgomery Silver Spring If Under 1 Year | Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 1 ☐ M 2 😿 F 237-16-5291 87 Yrs. July N.C. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be maitined at 1 ☐ Yes 2 ☐ No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 600 Winhall Way USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other the any hiury or other trained any hiury or other trained. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify: ģ 3 ₩ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elbridge G.Bostic Elizabeth Lorena Henry ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code2090419a. Informant's Name/Relationship (Type. Print) 12506 Buckley Drive Silver Spring, Md Christina E.Canfield/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2/18/2009 Silver Spring, Md Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of funeral Service License PHILIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mediastinal adenopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failure to thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Urosepsis Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 NOther (Specifical ughter's Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred home 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17,2009 N77928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila Bahadori MD 10301 Georgia Ave. #304 Silver Spring, Md 20910

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Box 68760,

P.0.

Division of Vital Records,

			·	pe or Print in					•	
			For State Registrar	State of Marylar		artment of <i>rtificate o</i>			71111	9 07227
		-	Registrar 1. Decedent's Name (First, Middle, Last)			Timeate	Dealli	2. Date of Dea		3. Time of Death
	Physicia /Medic		JAMES EDWARD ROSS					Month 2/15/20	Day Year	10:38 a [™]
1	Examin		4a. Facility Name (If not institution, give st			4b. City, Town	, or Location of Death	1	4c. County of Dea	
1	Funeral		SOUTHERN MARYLAND 5. Social Security Number 6. Sex	HOSPITAL 7. Age (In yrs	. last birthday	CLINTO If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth	PRINCE G. 9. Bi	rthplace (State or Foreign
	Director			M 2□F 76	Yrs.	Months Day	s Hours Min.	(Month, Day	TD *	ountry) mingham,AL
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Le	ocation				10d. Inside City Limits
	Maryla Fed a	to.	Maryland Prince Ge	orge's For	estvil	16				1X∑Yes 2 ☐ No
	or 28a	Director	10e. Street and Number	orge s ron	CBCVII.	10f. Zip Code)	1	0g. Citizen of What C	ountry?
	s 23a	eral I	3338 Princess Stepl		10	207			United Sta	
(0	fter de r item	Funeral	11. Marital Status 1 □ Never Married 2 Married	 Was Decedent Ever in L Armed Forces? 1 XYes 2 ☐ No 	J.S. 13.		f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)		te, etc.
215-0036	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, I'm Medical Evers has ruled be neithed at	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🖾 N	o Specify:		Specify: B1	ack
15-(- 3 60	Completed	15. Decedent's Educa (Specify only highest grade		16a. Dece	edent's Usual Occ e kind of work don DO NOT use reti	cupation ne during most of wor ired)	king	16b. Kind of Business	s/Industry
_	filed within Hygiene. Ither than "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		litary	,		Governmen	t
	tal Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
Maryland		2	Willie Ross	0.00	40- 14-7	·	Fannie M		y r, City or Town, State,	Zin Code)
Mai	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type Pamela Ross / Wife	e. Print)		,			restville,	
Je,	ges 1 and 2 It of Health If Item 27 or other tra		20a. Method of Disposition	20b.		osition (Name of ematory or other p		Date	20c. Location - City or	
Baltimore,	Pages ment of tant: If Its jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Fo	rt Lin	coln	2/2	1/2009_B	rentwood,	Maryland
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses	- ~ ~ ~ ~ ~ ~					1 Homes, P	
	_		23a. Part 1. Enter the disease, or complic	ations that caused the dea					ille, Mary rest,	Approximate Interval Between
Ang	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	LUNG	CAN	ical				Onset and Death
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	uted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	RENAL	FAIL	VRE				
0,	e exec ian an irial-tr		resulting in death) Last	Due to (or as a conse	. ,	122				
68760,	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	d.	LEUKOI	PENI	4				
Box 6	certifi nding ise as	J/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregr					23d. Date of de	elivery
B.	death e atte	sicial	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic pregna ☐ Other (specify)			Month	Day Year
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ds,	ires that signed I d be det	þ	Part II. Other significant conditions conf	ributing to death but not re	suiting in the i	underlying cause	given in Farti.		es 2 No 3 F	
Records,	w require been significations should b	letec						24a. Was a	an 24b. Were a	autopsy findings available
Re	The la	Completed						autop perfor 1 □ Yes	sy prior to meel? death? 2 □ No 1 □ Ye	completion of cause of
Vital	sician: The law certificate has the certificate has the lirector, page 2 si	Be C	25. Was case referred to medical examiner?					ath (Check only or	-	
of \	Physic this c	2	1 ☐ Yes 2 No Ho 27. Manner of Death	ospital: 1 Inpatient 2	ER/Outpatie	III 3 LI DOA			ence 6 Other (Sp ow injury occurred	ecify)
O	ding Phys th. : After this funeral dir	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury		njury at vork? □Yes 2 □No	Zod. Describe ii	ow injury occurred	
Division	If or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, si	treet, factory, offic	ЭӨ	28f. Location (S City or Tow	Street and Number or F	Rural Route Number,
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		ician: To the best of my kr er: On the basis of examir and manner stated.						
	To the within To the Compl	Me	29b. Signature and title of certifier	Cri	-	29c. Lice	ense number		29d. Date signed (Mor	nth, Day, Year)
			LASHEGO ABACE			MO	453	29 F	EBRUARY	19 2009
R	- 7		30. Name and address of person who cor	npleted cays of death (Ite	em 23a) (Type	Print)	Olinton	mol	1/1725	
) 	Sta	ite	31. Date filed (Month, Day, Year)	. 32. Registrar's Sign	nature	SKU	C111701	1,1167	40133	
	Registr		FFA 2 3 2009 Sens	. 32. Registrar's Signature	uti					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year **Physician** Month 1500 AM DOROTHY L. RUSH 28, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner ()ra Jursing رو Home Harra If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 3/12/1919 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 □ M 2**X** F Virginia Director 212-28-5317 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Harford Street 1 ☐ Yes 2 ☐ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21154 USA 3143 Old Scarboro Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ∏Yes **2√**∏No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3XXVidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marker Manufacturing permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other this any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Maines Blanche Bebber ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee A. Taylor/Executor 1940 Glenroths Drive, Abingdon, 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Bel Air Mem. Gardens 3/4/2009 Bel Air,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility C. Kobert Harkins Funeral Home, 600 Main, Delta, PA 17314 23a. Part1. Enter the diangles, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chimic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence off Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 movid 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 □ Unknown ۵. Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to re cause of death? Completed by Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed res 2 No page 1□ Yes or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of

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State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** T6 2009 February Edith Elizabeth Shoemaker 11:10 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Davidsonville 1350 W. Central Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. 01/29/1936 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F 73 219-34-7591 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 24 No Directo Anne Arundel Davidsonville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 1350 W. Central Avenue 21035 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Its Me 31 once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Home Dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berry A. Garner Christine H. Norfolk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1350 W. Central Avenue, Davidsonville, MD 21035 Melvin R. Shoemaker/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cemetery 02/20/09 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signature of Fune at e Island Rd., Edgewater, MD 21037 2973 Solomons Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown has been signed by a 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 1 ☐Yes 2 XNo 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes No 27. Manner of Death Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No investigation I Director: d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Nonth, Day, Year)

State Registrar 31. Date filed (Month

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 07231 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** 2009 Marguerite Ursula Byrne 11:31 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 12/19/1921 87 065-12-8116 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinator must be notified at Funeral Director 1 Yes 2 □ No Worcester Ocean City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9202 W. Biscayne Dr. 28142 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 Ϊ No Specify: Completed by 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne McGrath Bernard Byrne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 15908 Letcher Rd., Brandwine, MD 20613 Penelope Beattie / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 2/23/2009 Dagsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Gerebra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 curnically introduced in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner neumonia attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No After this certificate I funeral director, page 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Anpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Division

Baltimore,

State Registrar Jason Szymala NU 31. Date filed (Month, Day, Year)

FEB 23

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beneral Hospital

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H64428

9733 Healthwy Drive Berlin, MD 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 07232

		1- For State Registrar			Ce	rtificat	te of	Death			Re	g. No.			0 / 12 0
Physici Iedical Exam		Decedent's Name (First)	ntho	ny Sant							Date of Deat Month February 2	h Dav	Year		ne of Death 43 hrs
		4a. Facility Name (if not in: Laurel Hospital	stitution, gi	ve street and n	umber)		41	c. City, Town, or Laurel	Location	of Death	- 3 v		ounty of D		
Funeral Director		5. Social Security Number 058 12 8123		Sex XM 2 F	7. Age (In yrs. 87	last birtho	lay) Yrs.	If Under 1 Yea Months Day			8. Date of Bir 05/31	1	/ Y YYY) 9	Birthplace Country) NY	(State or Foreign
ie Maryland or 28a-f show any fied at once,	tor			mery		, Town or lver		ing						1	nside City Limits Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 3144 Gracefi	eld :	Rđ GV T	16			10f. Zip Code 2090	4		10	og. Citizen Unit		Country? tates	
fler death wi I", or items ner must be	by Funeral	11. Marital Status 1 Never Married 2 3 X Widowed 4	Divorce	d Armed F 1 X Yes d If Yes, Give Ye	² No No 1943-4	5	If Ye	Decedent of His s, specify Cubar Yes 2 X No	specify:	, Puerto Ri	can, etc.)	Specify: White			- 3
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natura	ompleted	15. Decedent's Education Elementary/Secondary (1-4 or 5+)	du		s Usual Occupat st of working life					irli		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens Important: I filen 27 is marked other than injury or other traumatic event, the Medical	Be Con	17. Father's Name (First, M Ralph Santon	elli	t)					Levia	a Mor		laiden Sur	rname)		
y MD 21; and 2 should be ealth and Men em 27 is mar traumatic eve	To	Joan Santore 20a. Method of Disposition				701	18 B	Address (Street raeburn of cer	Plac	e Be		, MD	2081		
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cree 4 Donation 5 Ott 21 Signature of Funeral Se	er Specify	<i>/</i> :	om State Arc	dent	or other	er place) mation	Srv.	2-23	-2009	Han	over	, MD	
Physician	0 30	23a. Part I. Enter the disea	e, or com	plications that of	MO1	19	411	2 Ola C	olumb	ма Р:	ike El.	Licot	t Ci	ty, M	FH Inc. D 21043
/Medical xaminer		failure. List only one of Immediate Cause (Final di or condition resulting in de	ease a	Atheroscle	rotic Cardiov		r Dise	ase	370			012		Betv	veen Onset and Death
ted I Insit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial events resulting in death)	ause ted C		consequence of				.,						
760, cate be executi physician and he burial - tran	n/Medical	UNPENDED		AMENDED											
Division of Vital Records, P.O. Box 68760, Inopital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sicia	IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9	t in the	1 Live t	outcome of preg sirth ant at time of de own	2 [I death 3 er (Specify)	Ectopic	pregnanc	у		ate of deli enth	ivery Day	Year
s, P.O. lirres that the signed by the detache	ed by Phys	Part II. Other significant c	onditions	contributing to	o death but not r	esulting in	the un	derlying cause g	iven in Pa	rt I.					se of death?
of Vital Records, g Physician: The law require. ther this certificate has been sineral director, page 2 should be	Completed	Ü									24a. Was a autops perfor	med?	prior deat	to completi	ndings available on of cause of 2 No
tal Rection: The	Be	25. Was case referred to m examiner?		Us in its i						(Check onl	y one)				
Physic at this	2	1 ✓ Yes 2 No			npatient 2				Other ₄	Nursing I		Residence		ther:	
Division of tall or Attending Pirs after death. An Director: After led in by the funera	Certification:	27. Manner of Death 1 Natural 5 Accident	Pending Investigat			28b. Tim		1 1	y at Work	No	3d. Describe h				
Division To the Hospital or Attency within 24 hours after death To the Funeral Directors completely filled in by the		3 Suicide 6 4 Homicide 29a. Certifier	Could not determine	d (Specify)	e of Injury - At h						or Town, St	ate)			te Number, City
To the Ho within 24 F	Medical	(Check only	Examine		st of my knowled of examination a tated.				, death occ			nd place,	and due t		
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(ot)		Pam ela É. Southa	II, MD	Assistant	Medical Exa	miner	111	Penn Street	, Baltim	ore, MD	21201	· •			
St Regist	ate trar	31. Date filed (Month, Day, FEB	242	009 32. Rg	gistrar's Signatu	ure .	bar	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Callie E. Sheets 10:43 3 AM 2 22 2 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Months Days Hours 245-46-9227 Director March 31, 1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 605 Marley Rd. 21921 Items 23a **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify Completed by If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced White "natural" the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Housewife 6 Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental မ Luther Eastridge Annie Orsborne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Joann Gilley/Daughter 1305 E. Old Philadelphia Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cherry Hill Cemeters February 26, 2009 Elkton, MD 21. Signature of Funeral Service Licensee 22. Name an Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Andrew G. Gee Funeral Home, 259 E. Main St., Elkton. MD 21921 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical equence of) Examiner Secreptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 DUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Dinpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17 2009 3:00 A Alton J. Summers February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth April 4, 1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 77 Maryland 218-34-5915 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show "natural", or items 23a or 28a-f shovidical Examiner must be notifiled at 1 ☐ Yes 2 No Director Maryland Charles Benedict 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 18844 Patuxent Avenue 20612 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Tavern Owner</u> Resturant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Leon Summers, Sr. <u>Lettice Caroline Turner</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Michelle Marie Mills/ Daughter 911 Copley Ave. Waldorf, Maryland, 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Feb. 19, 2009 Waldorf, MD. Huntt Crematory 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licenses MØ1190 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Cardio vascular disuase Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed ending physician and use as the burial-tran-Due to (or as a consequence of) Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ chronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Renal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No mellit 24a. Was an autopsy performe Hypertensive or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Luvaria 50653 2009 Gyon - C. Sysama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851-Deale churchton Road Deale 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 0 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^Day, 2009 February E **Physician** Anna Pauleen Sorensen 10:00am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Transitions Health Care Sykesville Carrol1 8. Date of Birth (Month, Day, Year)
Sept 18, 1 9. Birthplace (State or Foreign Country) Missouri If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 2□F 496-10-9233 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits MD Carrol1 Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 Sweet Air Lane 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Hommes Lillie Henning 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul Sorensen 6614 Sweet Air Lane Sykesville, MD 21784 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 4 Donation 5 Dother (Specify) Feb.23, 2009 Annapolis, MD 21. Signature of Funeral Service Licensee HATGHT FUNERAL HOME & CHAPEL PA PO Box 195 Sykesville, MD 21784 400764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' certificate 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ 10 Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 2 ours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WIL 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Read Westmin A. MAHMOUD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / I		rtment of H tificate of L		ientai Hygi Re	ene g. No.200	9	07236
ı	Physicia		1. Decedent's Name (First, Middle, Last) Linwood Daniel Shockley				2. Date of Death Month February		800	3. Time of Death 6:50 p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 30891 Dagsboro Road		4b. City, Town, or Salisb	Location of Death		4c. County of		0
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 011−26−0427 6. Sex 86	irthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/04/19	Year) 922		place (State or Foreign ntry) yland
	ryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow						1	0d. Inside City Limits
	the Ma	Director	Maryland Wicomico Sa	alisb	10f. Zip Code		10	g. Citizen of Wh	nat Cour	1 ☐ Yes 2 X No
	ath with	eral Di	30891 Dagsboro Road	10.141	21804		a if Was a Na	USA	Ai	
036	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Madical Examination in 181 by morthly at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of Hi Yes, specify Cuba □Yes 2 X No	ispanic Origin? (Spen) In, Mexican, Puerto Specify:	Rican, etc.)		White,	can Indian, etc. white
15-0	in 72 hc n "natul	Completed	(Specify only highest grade completed)	(Give k	ent's Usual Occup ind of work done o O NOT use retired	durina most of worki	ng	6b. Kind of Bus	ness/In	dustry
212	filed with Hygiene ther tha		9 - fa	armer	:	18. Mother's Name	/First Middle N	agricul		e
land	e d al	To Be	17. Father's Name (First, Middle, Last) Walter Daniel Shockley			Lelia Et		,		
, Mary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Anna Hastings/daughter	3062	20 Dagsbo	and Number or Rura	Salisbur	y, MD 2]	L804	
Baltimore, Maryland 21215-0036	permit. Pages 1:8 Department of He Important: If iten any Injury or oth		20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		ition (Name of atory or other place Memorial		/09 /	Salisbu	ıry,	MD
Ball	permit Depar Impor any In once.		21 Signature of Funeral Service Licensee A. Dompson (FSF	22.	Name and Address Holloway 501 Snow	ss of Facility Funeral Hill Rd.	Home, Pr , Salisk	ofessio oury, MD	nal 21	Association 804
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence		-	1			-	
	Examiner	e.	Sequentially list conditions, if any leading to immediate	of):	votes	Chine	1			
	acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c							
68760,	uficate be executed g physician and as the burial-transit	edical Ex	Due to (or as a consequence	e of):						
	certifica ding ph se as th		IF FEMALE: 23c. If yes, outcome of pregnancy					22d Date	of dativ	
.O. Box	The law requires that the death certifinate has been signed by the attending I bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		Ectopic pregnance Other (specify)	у		23d. Date Mon		Day Year
S, P.	ires that signed b	ρ	Part II. Other significant conditions contributing to death but not resulting	in the und	derlying cause give	en in Part I.	23e. Did tob			the cause of death?
Corc	w requir s been s should	leted	THE TOWNER				24a. Was ar	24b. W	ere auto	opsy findings available
Vital Records,	Physician: The law r this certificate has t ral director, page 2 si	Completed					autops perforn 1 □Yes 2	ned? de	eath?	ompletion of cause of 2 □ No
VIII VIII	rsician s certifi firector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/O	Outnatient	3 DOA Oth	26. Place of Deatler:	me 5 Reside		(Speci	(f ₄)
n of	ding Phy h. After this funeral c	on: To		. Time of Injury	28c. Injur Work	y at	28d. Describe ho			
Division of	Atten ar deat ector: by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)	farm, stre		Yes 2□No	28f. Location (St. City or Town		r or Run	al Route Number,
	pital or ours afte eral Dir filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge			me, date and place.			ner as	stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.		estigation, in my o	ppinion, death occur	red at the time, da	ate and place, ar	nd due t	o the cause(s)
	P with Too	Z	29b. Signature and atterof certifier		29c. Licens	さい b フィ	, 25	2 \17(Day, Year)
	Irdn		30. Name and address of person who completed cause of death (Item 23a)			1 ~ 14	, Sal-	160071	N	10815 pr
	Sta Registr		31. Date filed (Month Pay Year) 32. Redistrar's Signature	1. 4	lan			7.		
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09-01305
Helen Stigile
Phys

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) sician/ Month Day February 13, 2009 1738 hrs Medical Examiner Stigile Ε. Helen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Havre de Grace Harford Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 12/02/1920 Country) PA Director 88 2**X** F Yrs 221-05-8803 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State any Yes 2XX No Wilmington New Castle DE 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Montal Hygiene Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 19808 5500 Fairmont Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. uneral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. must be Armed Forces Never Married 2 Married 2 X No Yes Specify: Yes 2 No specify white If Yes Give Year 3 X Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Joseph Bancroft & Sons marked other than " event, the Medical Lab Technician 21215-0036 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Andryaitis John H. Mangold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Livonia, N.Y. 5709 Hillside Drive 27 is Thomas R. Stigile, Sr. B nt of Health a t: If item 27 other traum: 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 X Removal from State 1 X Burial 2 Wilmington, DE 2 /18/2009 Silverbrook Mem. Park Other Specify 22. Name and Address of Facility
McCrery Funeral Homes, Inc. 3924 Concord Pike 21. Signature of Funeral Service Licensee NOO 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: signed by the attending phy be detached for use as the b Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 🗸 Unknown ģ History of deep venous thrombosis, Pulmonary Edema Completed 24a. Was an 24b. Were autopsy findings available Division of Vital Records, has been si 2 should b prior to completion of cause of autopsy death? performed No Yes 2 V No page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Hospital: 1 Other; Residence 6 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification Yes 2 No 1 V Natural within 24 hours after death

To the Funeral Director: A
completely filled in by the fun Pending Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 14, 2009 O.C.M.E. - 1/MD 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Signature

ORIGINAL

Breaking

State

Registrar

31. Date filed (Morth D. Y.)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2:15 Physician 2009 Clara May Somers February 19. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex 1 ☐ M 2 🔯 F Months Days Hours Min. 87 March 24. Maryland 215-18-0433 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 49505 Airedele Road 20680 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 TXTNo Specify. Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laundry Room Worker Navy Exchange 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janie Fish Sanner Wilbur Wesley Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 516, Ridge, Maryland 20680 Department of Health Important: If item 27 any injury or other to once. Brenda A. Raley / Daughter 20b. Place of Disposition (Name of cometen, crematory or other place). 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State February Methodist Cemetery Ridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23, 2009 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licenses P.O. Box 270, Leonardtown, Maryland 20650 Kennetk Approximate Interval Between Onse and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the rashock, or heart failure. List only one cause on each line. s cardiac or piratory arrest Immediate Cause (Final disease or condition resulting in death) nsequence ON. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ANo 9 Unknown 23e. Did tobacco use contribute to the cause of death? re to death but not resulting in the underlying gause given/in, Part I. Part II. Other significant conditions 1 ☐ Yes 2 B No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 No 1 □ Yes 2 No 25. Was re re rrin to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🐼 Natural 1 ☐Yes 2 ☐ No

Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760, signed by the a d be detached for this After

Funeral

Director

ral", or Items 23a or 28a-f shov Examiner must be notified at

"natural", or

er than "nature the Medical E

Health and Mental Hygiene. em 27 is marked other thar ther traumatic event, the M

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Certification: To 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier (Check only one) and manner stated.

within 24 hours a To the Funeral D completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 2 dause of death (Item 23a) (Type, Print) 30. Name and address s/of person who completed 240%5 Three Notch Road, Hollywood, Maryland 20636 James P. Jarboe, M.D. 3. Registrar's Signat 31. Date filed

State Registrar

			For State Registrar	State of	Marylan	nd / Depa <i>Cer</i>		nt of H te of D		and M			e 2009	0	7239
			Registrar Decedent's Name (First, Middle, Last,	,							2. Date of De	ath			ne of Death
	Physicia /Medic		Jerome Snider								Month Februa	ry 1	7, 2009	11:	00 a M
1	Examin		4a. Facility Name (If not institution, give	street and num	nber)		4b. City,	Town, or	Location o	of Death		40	c. County of Dea	th	
1			3 Arrowood Terrace			1 - 1 6 2 46 4 - 2	Beth	esda	If Under:	24 Hre T	9. Data of Bir		ontgome	-	tate or Foreign
	Funeral		5. Social Security Number 6. Sec. 10	x 81.M 2□F	7. Age <i>(In yr</i> s. 80	(ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 07/08/	un ay, Year 1928	Was	ountry)	on, DC
-	Director		Usual Residence of Decedent								077007.	1,20	Was		
	yland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								de City Limits
	e Mar	Director	Maryland Montgome:	су	Bet	hesda									Yes 2 No
	ith th		10e. Street and Number				10f. Zi						itizen of What Co		
	sath v	eral	3 Arrowood Terrace	12. Was Deced	dent Ever in II	S 13 \	208		spanic Ori	gin? (Spe	cify Yes or No		ed Stat		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Vigiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhal Trust be notified a once.	y Funeral	1 ☐ Never Married 2 ☒ Married	Armed Ford 1 [X]Yes 2 If Yes, Give	ces? ^{2 No} 946	_ '	fYes, spe I∐Yes	cify Cubai	n, Mexican Specify:	, Puerto I	Rican, etc.)		Black, Whit		
2-003p	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu		ites: 1947	16a. Deced	dent's Usu	al Occupa	ation			16b. l	Kind of Business	/Industry	
<u> </u>	in 72	Completed	(Specify only highest grad	e completed)	45-1	i (Give	kind of wo	ork done d ise retired;	lurina mosi	t of workir	ng			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
7	with giene r thai	EO	Elementary/Secondary (0-12)	College (1-	-40r 5+)	Mercha	ant					Gr	ocer		
<u>p</u>	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)								(First, Middle	, Maide	n Surname)		
Jand	Menta Menta arked atic e	2	Louis Snider]	Lilli	an J	eweler				
Mar	2 sho and is ma raum		19a. Informant's Name/Relationship (7)				•	•					or Town, State,		-
e,	1 and Health Sm 27 ther t		Elaine I. Snider, 120a. Method of Disposition	wife	20h I	3 Ar1			rrace		thesda		ryland -ocation - City or	2081	
ב ב	nt of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ F		1 6	cemetery, cren rden of morial	natorv`or	other place	ance.				•	,	
altimor	nit. Parantme artme ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Me Donald	morial C 22	Park Name a	nd Addres	i U ss of Facilit	12/19 N	/2009	СТа	rksburg	, Mar	yıand
ä	Dep Imp	e d	Sandy C State	thruser.	\$68564	emyerDa	anzar 170 F	sky-	Goldb 111e	erg	Memoria Rock	al C vill	chapels, e, Mary	Inc. land	20852
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ication that ca	aused the deat	th. Do not ent	er the mo	de of dying	g, such as	cardiac c	or respiratory	arrest,	,	Approx	
1	Physician	i g	Immediate Cause (Final disease or condition		Cancer									Onset	and Death year
	/Medical		resulting in death)		or as a consec									One	<i>y</i> • • • • • • • • • • • • • • • • • • •
	Examiner		Sequentially list conditions.	b											
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consec	quence of):									
5	xecut and Il-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (r	or as a consec	quence of):								-	
2/20	icate be executed physician and s the burial-transit	dical E		ď											
Ω	tificate g phy as the	edic		J	-									ľ	
X Q Q	death certifi e attending id for use as	M/us	23b. was decedent pregnant	23c. If yes, outo	come of pregn] Ectopic	pregnancy	,			(2)	23d. Date of de		V
	w requires that the death certific been signed by the attending is should be detached for use as	Physician/Me	in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		ant at time of		Other (s						Month	Day	Year
7.	hat th	Phy	Part II. Other significant conditions co	ntributing to de	eath but not res	sulting in the u	nderlvina	cause give	en in Part I		23e. Did	tobacco	use contribute t	o the caus	e of death?
Vital Records,	requires that the neen signed by th hould be detache	d by	, and in other organizations are			g	,				1 🔼	Yes 2	2 □ No 3 □ F	robably	4 🗌 Unknown
Ö	w requ	Completed									24a. Was	an	24b. Were a	utopsy find	dings available
2	The law ate has b	шc									auto	ormed?	prior to death?	completio	n of cause of
ta		a)	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes (Check only		io i i i te	s 2□No	3
	Physician; r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🔲 lt	npatient 2	ER/Outpatier	nt 3 🗆 C	OA Othe	er: 4 🗆 Nu	ursing Ho	me 5⊠Res	idence	6 ☐ Other (Sp	ecify)	
0	ng ftel	L:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Monte	of Injury h, Day, Year)	28b. Time of Injury		28c. Injury Work	y at </td <td> ;</td> <td>28d. Describe</td> <td></td> <td></td> <td></td> <td></td>	;	28d. Describe				
<u> </u>	Attending ir death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				M		Yes 2□		206 1	/O1 .		(D	No. of the contract of the con
Division of	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place buildir	of Injury - At h ng, etc. (Spec	nome, farm, str ify)	eet, tacto	ту, описе			City or To	wn, Sta	and Number or F te)	iurai Houte	Number,
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 24 Certifying Phy	sician: To the	best of my kn	owledge, deat	h occurre	d at the tir	ne, date a	nd place,	and due to the	e cause	(s) and manner	as stated.	
	ie Hos n 24 h ie Fui	Medical	(Check only 2☐ Medical Exam one)	iner: On the ba and mann		ation and/or in	vestigatio	n, in my o	pinion, dea	ath occurr	red at the time	, date a	nd place, and du	e to the ca	use(s)
	To th within To th	M	29b. Signature and title of certifier	0	^		25	c. License		0			ate signed (Mor		
	10		Ihom	_ اه	-ch			DC-₩	D1256			ret	oruary 1	∪ , ∠\	
	10		30. Name and address of person who c					10 NT	T.7 T.7	ah !	oter	DC	20016		
	01-		Thomas L. Sacks, M		L New M egistrar's Sign		Aveill	ie, N	w, wa	SHIL	ig coll,	טע	20010		
	Sta Registr		FEB 2 0 2009	Bened		back	2								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amedn #11, per FH 6889 3/17/09 TT ype or Frin in Place 3/17/09 TT
#11, per FH (889"3/17/09 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 10:50a^M Feb. 17, 2009 Sherry John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery #404 4720 Chevy Chase Drive If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠** M 2□ F 067-18-7742 83 York Director New Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 □ No Chevy Chase Item 27 is marked other than "natural", or items 23a or 28a-f slother traumatic event, the Wedical Examiner of the mail be mailfaed. Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4720 Chevy Chase Drive #404 20815 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after Tanever Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No þ 3 Widowed 4 Divorced Year or Dates: 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Political Officer Federal Government 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne Wilkinson Alden Sherry ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2081519a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health ar Item 27 is 4720 Chevy Chase Dr.#404 Chevy Chase, Md Joan M.Sherry/Wife permit. Pages 1 a
Department of He
Important: If Item
any Injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bemoval from State Chesapeake Crem. 2/19/2009 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service Consee PATTY AD. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial infarction Die to (or as a consequence of): hours resulting in death) /Medical Examiner years Cardiopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine years Hypertension attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 certificate be Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 0 the 8 ☐Yes 2☐No 9 ☐ Unknown signed by t σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No To the Hospital or Attending Physi-within 24 hours liter death.

7 To the Funeral Director. After this completely filled in by the funeral director. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Peb. 18, 2009 D33844 20 30. Name an addr so of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Joseph Vassallo MD

31. Date filed (Month, Day, Year)

FEB 20

DHMH 17 Rev 1/2001

3. Registrar's Signature

5454 Wisconsin Ave #925 Chevy Chase, Md 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per Inf G890 4/23/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Feb. **Physician** 27, Dorothy Lee Scott 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakland Garrett Garrett Memorial Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace *(State or Foreign Country)*Maryland 8. Date of Birth
(Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 XX Months Hours Min. 80 232-56-5806 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits I Hygiene. other than "natural" or items 23a or 28a-f show rent, the Macked Examinar must be notified at 10a. State 10b. County 1 Yes 2 □ No Director WV Tucker Thomas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26292 USA P.O. Box 294 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📉 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐ Yes 2**X∏X**No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WV Department of Elementary/Secondary (0-12) 12 College (1-4or 5+) Corrections permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, Ins. once. Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Mae Nestor Elmer Gay Plum ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POBox 294 Thomas, WV 26292 Nellann Scott/Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/1/2009 Davis, WV Davis Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licensee Hinkle Funeral Home, Inc. POBox 186 Davis, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician IW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-fransit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Ye ar 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □No Division of Vital 1 □Yes 2-2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

29b. Signature and title of certifier

Thomas Johnson, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

311 N. 4+hst.

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	larylan	d / Depa	artment o	f Health	and M	ental Hy	gieme Reg. No.	009	07242
	Physici /Medio		1. Decedent's Name (First, Middle, L MARY JEAN SIVIC	Last)						2. Date of De Month 03	O2 Day	2009°	3. Time of Death O955 A M
	Examir		4a. Facility Name (If not institution, g FROSTBURG VILLA	GE NURSING	CENT		FROSTE				AT	County of Deatl	
· ·	Funeral Director		236-24-5407	. Sex 7. A 1 ☐ M 2 🔀 F	ge (In yrs. 87	iast birthday) Yrs.	If Under 1 Ye		Min.	8. Date of Bir (Month, Da 01 1	th Year)		nplace (State or Foreign Intro) VTRGINTA
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County	NTS/		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Director	MD ALLEGA 10e. Street and Number			031000	10f. Zip Coo	de			10g. Citi;	zen of What Co	untry?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notilled at	by Funeral	10209 PINEY MOUN 11. Marital Status 1 Never Married 2 Married 3 2 Wildowed 4 Divorced	12. Was Deceder Armed Forces	it Ever in U. ? No		Was Decedent If Yes, specify (Cuban, Mexica	n, Puerto F	cify Yes or No Rican, etc.)	0- 1	14. Race - Amer Black, White	
21215-0036	d within 72 hou giane. er then "natura the Madical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		r 5+)	(Give	dent's Usual Od kind of work do DO NOT use re	one during mos tired)	st of workir	ng		nd of Business/I	·
Maryland	should be filed nd Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, La JOHN JONAS	st)						(First, Middle CHAR JC		Sumame)	
	and 2 sho saith and n 27 is mu		19a. Informant's Name/Relationship WILLIAM SIVIC, J	ES ESSENTES	T.		ng Address (Str					r Town, State, Z 532	ip Code)
Baltimore,	Pages 1 and 3 tent of Health nt: If Item 27 ity or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from Stat	20b. P	Place of Dispo	osition (Name or matory or other ND CREM	f place)	D	ate	20c. Lo	cation - City or	Town, State MD 21502
Balti	permit. Pages Department of I Importent: If Ite any injury or or anges.		21. Signature of Funeral Service Lic	censee	2547							HOME, MD 2153	
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ity one cause on each	line.					r respiratory a	arrest,		Approximate Interval Between Onset and Death
*	/Medical Examiner	70	resulting in death)	b. VALVO	IS a conseq	uence of):	N-Fa	ISEAS.	E				
3760,	ate be executed sysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	uence of):):								
P.O. Box 68	The law requires that the death certificate be executed whe has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3	∃Ectopic pregna ∃ Other (specify		-		2	23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	þ	The state significant continuous to the state of the stat									the cause of death?	
Vital Records,		Completed								24a. Was auto perfo 1 🗆 Yes			topsy findings available completion of cause of
Vita	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatier	nt 3 DOA	Othon		(Check only ne 5□ Res		G □Other (Spec	infv)
Division of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		27. Manner of Death 1 SNatural 5 Pending 2 Accident investigat	28a. Date of in (Month, L	ijury	28b. Time o Injury	f 28c.	injury at Work? 1 Yes 2	2	28d. Describe			
Divis	s after de	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ed 286. Place of I	njury - At ho etc. <i>(Specif</i>		reet, factory, off	ice	2	28f. Location (City or To	(Street and own, State)	d Number or Ru)	ral Route Number,
	ne Hospit n 24 hour he Funera	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be- caminer: On the basis and manner	of examina	owledge, deat ation and/or in	th occurred at the overtigation, in r	ne time, date ai ny opinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
)	To the To the comp	Σ	29b. Signature and title of certifier	ically				cense number				e signed (Monti	2009
			30. Name and address of person when Hay II+ Sold		death (Item	n 23a) (Type,	Print) Walsh	Rd (Cumb	erland	mo	2150	a .
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ature	bad					2150	

DK-

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month George **Physician** Smith Richard p^{M} 27, 2009 9:28 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 805 East Sixteenth Street Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Days 1 152 M 2 □ F Months 213-42-1694 64 Director June 1. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhese once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Frederick Frederick Maryland 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 805 East Sixteenth Street 21701 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bealuh Annamary Huffer John Atkins ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Smith / Wife 805 East Sixteenth Street, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 3 1

Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 21. Signature of Funera M01433 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the state of the sequence of the Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lone FREDERICK MD 21702 BAU6HMANS JULIO 7.1) -110 MENOCIM 31. Date filed (Month, Day, State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		4	For State Registrar	State of Ma	aryland			nt of He te of D				giene Rog. Nd	2009	0	7244
	€.		Decedent's Name (First, Middle, Last								2. Date of Dea		Yea	1	Time of Death
	Physicia		GLENN WILLARD SHIE	LEY							02	25	200	9 2	:45 P M
	/Medic Examin		4 City Town or Location of Death								4c.	County of De	eth		
			DEVLIN MANOR HEALT					MBERL		0411			LLEGAN		101.1
	Funeral		5. Social Security Number 6. Se	x 7. Ag JM 2□F		ast birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day 07-16-	h y, Year) 107, 3	9. B	Country)	(State or Foreign LVANIA
8,	Director		189345151 Vsual Residence of Decedent		65	113.					07-10-	1743	FE	ININDI	LVANIA
	and		10a. State 10b. County		10c. City	, Town or Lo	cation								nside City Limits
	Mary -1 sh	tor	PA BEDFORI)	AR'	TEMAS								1	I ☐ Yes XX No
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	death with the Maryland ims 23a or 28a-f show	Funeral Director	501 SILVER MILLS H	ROAD				1721					.S.		
	ems ems	ıner	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13. \	Was Dece f Yes, spe	dent of Hi orfy Cuba	spanic Or n, Mexica	rigin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - Ar Black, Wi		ndian,
36	hours after tural', or Ite	by Fu	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1XX es 2 ☐ If Yes, Give	1966	-	1 🗆 Yes	21X No	Specify	:			Specify: V	WHITE	Ξ.
Ş	tural'		15. Decedent's Edi	Year or Dates:		16a. Deced	dent's Usi	al Occupa	ation			16b. Ki	nd of Busines	ss/industr	ту
င်	filed within 72 Hygiene. other than "nai	Completed	(Specify only highest grad	le completed) College (1-4or	5.\	(Give	kind of w	ork done d use retired	during mos	st of worki	ng				
212	y with	E	Elementary/Secondary (0-12)	College (1*40)	3+)	JAN	ITOR	IAL				ICE	CREAM	IND	USTRY
פַ	be filed ntal Hygie od other	Be C	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden	Sumame)		
a	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Ind Mental Hygiene. Is marked other than "natural; or tlems 23a or 28a-1 show unatic event, the Mauksal Examplan in that be mailited at	10	STANLEY R. SHIPLEY	Z		-					I. AKER				
Maryland 21215-0036	2 sho and is m		19a. Informant's Name/Relationship (7								A DEFEMA				de)
	1 and Health em 27 ther tu		MABEL G. SHIPLEY 20a. Method of Disposition	/ WIFE	20b. P	dace of Dispo			ירט צ		ARTEMA		cation - City		State
פֿר	Pages nent of H		1 ☐ Burial 2XX remation 3 ☐		, c	emetery, crer STONE	natory or	other plac		02-2	7-09	TYRO	NE PA	7	
altimore,	it. Partmer artmer artant injury		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License		KLI			and Addres			mmermar				1 Home
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e <u>once</u> .		H. Martin Den	meiman	J.	4.	5 S.	Car1	isle		Greenca				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	d the death	h. Do not ent	er the mo	de of dyin	g, such as	s cardiac c	or respiratory a	rrest,		Apr	proximate erval Between
	Physician		Immediate Cause (Final disease or condition	PEPE	ROF	1/4	001	LAG	2	AC	CIN	30	1	On	set and Death
	/Medical		resulting in death)	Due to (or a:	s a consequ	uence of):	26.01	p-111		/					
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	D its	lner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury												
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Вох	leath certific attending p	Z	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcom	e of pregna	ancy	Tectonic	pregnancy	,				23d. Date of	,	
Ď.	death e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a			Other (Month	Day	y Year
P.O.	that the de ed by the detached	Physician/Me	9 🗆 Unknown								an- Did			- to the o	auno of dooth?
	The law requires that the death certific the has been signed by the attending proage 2 should be detached for use as	þ	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	inderlying	cause giv	en in Part •	(I.		Yes 2		Probably	ause of death?
ord	w requir been s should	ted	CORUNARY	17X (E	3-7			15/-			-				
Records,	has by	Completed									24a. Was	psy	24b. Were prior death	autopsy to comple	findings available etion of cause of
H		So		performed? 1 Yes 2						2 No			3NO		
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		lene		Oth	100		h (Check only		6 DOther /6	Canada)	
ō	Phys r this ral di	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpat	jury	ER/Outpatie 28b. Time o		28c. Injur	y at		me 5 Resi 28d. Describe			респу)	
on	Attending ir death. ector: After by the fune	tlor	1. Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	М	Wor 1 □	rk? Yes 2[□No					
Division	Atter r dea ector by the	ifica	3 Suicide 6 Could not be determined	286. Place of 1	njury - At h		reet, facto	ory, office			28f. Location (Rural Ro	oute Number,
Ö	s after or	Certification:	4 Difficial	Dollaring, V	oto. (Opoon										
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	ysicien: To the bes	of examina	owledge, dea ation and/or in	th occurre	d at the tir	me, date a	and place, eath occur	and due to the red at the time.	cause(s , date an) and manner d place, and	r as stated due to the	d. a cause(s)
	To the h within 24 To the f complete	Med	one) 29b. Signature and title of certifier	and manner s	stated.		1 2	9c. Licens	e number	r		29d. Da	ite signed (M	onth, Day	r, Year)
	Viii To	-	230. Signature and title become	10	1			Dotor	15	ZICK	04		120	10	000
			30. Name and address of person who	Completed cause of	death /lto-	m 25a) (Tura	Print)	Y	10	74	4/		7-	16	007
			DR. SHIV KHANNA			NATIONA		GHWA	Y LA	AVALE	, MD 21	.502			
	St	ate	31. Date filed (Month, Day, Year)		strar's Sign	ature	has								
	Regist	rar	MAR 0 9	ARM AL	CALLED .	A S	MA A								

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 17, 2009 Theodore Herbert Taylor 1:25 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) June 25, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 € M 2 □ F Months Days Hours Min 219-12-3441 88 Virginia 1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County Maryland Anne Arundel Annapolis 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28 Williams Drive 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑No Specify: White Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deputy Comptroller State of Maryland 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Malcolm Slicer Taylor Agnes Louise Fish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Dapkunas/daughter 610 Tayman Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Baltimore Crematory 2/23/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Juneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home

Department of Health a Important: If Item 27 Is any injury or other traconce. **Physician** /Medical

The law requires that the death certificate be executed

attending pl

been signed by the should be detached

After this certificate has I funeral director, page 2 s

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

To the within 2

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Directo

Funeral

2

Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
snt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show yor or other traumatic event, the Medical Expanding russ to profitted at my

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit

U 23a. Part 1. Enter the disease, or shock, or heart failure. List

	147 buke of Gloucester St., Afriapor.	IS, MD 21401
	ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line.	Approximate Interval Between Onset and Death
a	Ventricular fibrillation	
	Due to (or as a consequence of):	
b		
,	Due to (or as a consequence of):	
. C		
	Due to (or as a consequence of):	
d		
23c.	If yes, outcome of pregnancy	of delivery

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? I □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural

4 ☐ Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed 1 □Yes 2 ☑No .24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

5 Pending investigation 2 ☐ Accident 3 ☐ Suicide

(Month, Day, Year) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28c, Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 00054903 29d. Date signed (Month, Day, Year)

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CK rederi

139 Old Solomon's Island Rd Arrayzoli Karkowski ud

31. Date filed (Month, Day, Year) FEB 1 9 2009 32. Registrar's Signature park

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 07246 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2009 Charlotte Thackston February 8:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug 10, 19 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs Director 79 1929 Georgia 254 40 0106 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director MD Howard Columbia 28a-f with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō items 23a 10029 Evergreen Avenue 21046 United States Funeral death v 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 P 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 2 Bookkeeper Grocery permit. Pages 1 and 2 should be filled. Department of Health and Mental Himportant: If item 27 is mornary injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mae Weissinger Humphrey Cato 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Thackston/Husband 10029 Evergreen Avenue Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-23-2009 Ardent Crematory Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Shem 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Day Month Year 5 Other (specify) the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown should s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed' certificate 1 ☐Yes 2X No 1 □Yes **2**√ No or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 2√ No 2 ER/Outpatient 3 DOA Medical Certification: To 1 XInpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural n 24 hours after death.

Reference of the function of the func 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Ccritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (4) (D) OKEST R 0AD 31. Date filed (Month 32, Registrar's Signature State Registrar

		•	1 - State Registered #19b, 2	2-27-09, per	FHDE	R, KACOLI	iticale of	Death		Reg. N		3 0724
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www.me.	/Media	al	1. Decedent's Name (First, Middle, L. MAR GAR 4a. Facility Name (If not institution, gi	EI NEW	1101	1 12	TYLOR TOWN	r Location of Do	FEB		c. County of Dea	
	Examir	er	HOWARD COUNT	Ve street and number)	1 14	STA1	COL	umB1,	4	"		VARI)
	Funeral					st birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of I	Birth		
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	yland Now		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	a-f sh	ctor	MD Howard		Colu	mbia						1 □Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code				Citizen of What C	ountry?
	ath wi	Funeral Director	6017 Jerry's Dr	~			21044			US	5A	
	tems	nue	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. W	as Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No-	14. Race - Am Black, Whi	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Eventher cust be putified at	Completed by F	1 Never Married	1 □Yes 2 ☑ N If Yes, Give Year or Dates:	10	1	□Yes 2 X No	Specify:			Specify: W	hite
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d 2	filled v Hygin		17. Father's Name (First, Middle, Las	 		HORRER	же	18. Mother's N	lame (First, Midd			
an	d be ental ked o	To Be	Ralph H. Newton					Louise	Tingley	•	,	
ary	shoul and M s mar umati	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	Address (Street	and Number or	Rural Route Nur	nber, City	y or Town, State,	Zip Code)
Σ	12 mg		Robert E. Taylor	r / Husband	1	16017	Address (Street	D ₅ ., C	glumbia.	¹₩D	MO 2109	3. .
ore	ges 1 ar it of Hea if item 3		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other pla	ce)	Date	20c.	Location - City o	Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Spec	(5 /)	Arc		remation		23-2009		over, M	
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or of once.		21. Signature of Funeral Service Cice	msee M01411		^{22.} 41	Name and Addre	ess of Facility H olumbia	arry H. Pike, E	Witz	xe's Fa xott Cit	mily FH, Inc y, MD 21043
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	Examiner	.	Sequentially list conditions	b. PN	EUN	1001	A					DAYS
	pe jis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):						,
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587	tificate ng phys as the	Medical		d								
Box	eath certi attending for use a	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catacia assenan				23d. Date of de	elivery
O. B	at the deat by the attertached for	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnand Other (specify) _	У		-	Month	Day Year
P.O.	that the		Part II. Other significant conditions	contributing to death bu	ut not result	ting in the un	derlying cause giv	en in Part I.	23e. Di	d tobacco	o use contribute	to the cause of death?
of Vital Records,	lires t	Completed by	74PE(2) DI	_		_			1[Yes	2 ™ No 3□ F	Probably 4□ Unknown
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Re	: The law cate has		LUNG CAR						- au	topsy rformed?	prior to	completion of cause of
ta	ian: The rtificate tor, pag		25. Was case referred to medical	VCCA				26 Place of I	1 ☐ Yes Death (Check onl)		No 1∐Ye	s 2□No
<u>></u>	ysician: is certific director,	To Be	examiner? 1 ∐ Yes 2 X No	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatient	3 □ DOA Oth	or:			6 ☐ Other (Sp	ecify)
0	ding Ph h. After th funeral	٦	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	rv 2	28b. Time of Injury	28c. Inju		28d. Describ			
Si	death. ctor: A y the fu	atic	2 ☐ Accident investigation	on				Yes 2 □ No				
Division	al or Attend after death I Director: A d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		iry - At hon c. (Specify)	ne, farm, stre)	et, factory, office		28f. Location City or 7	(Street own, Sta	and Number or F ate)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) Certifying F	hysician: To the best of the basis of and manner sta	f examination	rledge, death on and/or inv	occurred at the ti estigation, in my	ime, date and pl opinion, death o	ace, and due to to courred at the time	he cause le, date a	e(s) and manner and du	as stated. e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier				29c. Licens				Date signed (Mon	
			h Joon	D Hospi	MAL	137	D	6800.	2	FE	8. 22	,2009
6	500		30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type, F	rint)	00/100	20:0	MA	21061	21
	700		TIN M. CO M. 31. Date filed (Month, Day, Year)	32. Rahistra	arle Signatu	U/ TK L	IHN E	CULUII	10114	UI	el 10 T	<i>T</i> .
	Sta Registi		FFR 2 4	2009	ا مناوات ا	A. 16	aked					
			1 hat 1 mg = 1	1000	-/	- 7						

State of Maryland / Department of Health and Mental Hygiene 27-09 per FHDR. KICHDiticale of Death Reg. No. 2009

07247

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Regist

	for State Registrar	nate of Marylan		rtificate of l		Re	g. No. 2009	9 07248		
ian ical	1. Decedent's Name (First, Middle, Last) Maynard Will:	iam Timme				2. Date of Death Month Februar	y 19, 2009	3. Time of Death 7:05 a ^M		
ner	4a. Facility Name (If not institution, give stre 10700 Coastal High			4b. City, Town, or Ocean	Location of Death	1	4c. County of Dea			
	110-14-7000	2□ F 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04/30/1	9. Bi 926 F.	rthplace (State or Foreign Country) Lorida		
	Usual Residence of Decedent 10a. State 10b. County	10c. City	v. Town or Lo	cation				10d. Inside City Limits		
호	10a. State 10b. County 10c. City, Town or Location Maryland Worcester Ocean City									
Funeral Director	10e. Street and Number 10700 Coastal High	hwav #2509		10f. Zip Code 2184		10	0g. Citizen of What Country?			
nera	11 Marital Status 12.	Was Decedent Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Am			
by Fui	1 Never Married 2 TV Married	Armed Forces? 1 XYes 2 No If Yes, Give Army Year or Dates:		f Yes, specify Cuba I □Yes 2 🛣 No		o Rican, etc.)	Black, Whi	white		
Be Completed by	15. Decedent's Educati (Specify only highest grade co	on ompleted) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work)	king	16b. Kind of Business	s/Industry		
Som	12	4	jewe	ler			fine jewe	elry		
To Be	17. Father's Name (First, Middle, Last) Carl F. Timme				18. Mother's Nam Rose Jo	ne (First, Middle, M DNES	laiden Surname)			
	19a. Informant's Name/Relationship (Type. Nancy Timme/wife	Print)		_			City or Town, State, Ocean City	Zip Code) Y, MD21842		
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	iovai from State I		sition (Name of natory or other plac			20c. Location - City o			
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2-10	22	y Cremato HOTIOWAY	Funeral 1	Home Prot	Salisbury Tessional	Association		
	23a. Part 1. Enter the disease, or complicati	ions that caused the death					ary, MD 21	Approximate		
	shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ause on each line. Mu faztatic	-					Interval Between Onset and Death		
	resulting in death)									
niner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events c.									
Medical Examiner	that initiated events c									
edica	d									
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	elivery Day Year								
/ Ph	Part II. Other significant conditions contrib	outing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?		
ed b						1 □ Ye	s 2 No 3 F	Probably 4 Unknown		
Completed by	24a. Was an autopsy prior to c death? 1 Yes 2 No 1 Yes									
Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		s 2□No		
	1 Yes 2. No Hosp	1 Inpatient 2			4 LI Nursing H		nce 6 ☐ Other (Sp.	ecify)		
ation:	2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	yat ?? Yes 2 □ No	28d. Describe ho	w injury occurred			
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	eet and Number or F , State)	Rural Route Number,							
dical (29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my kno on the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, da	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)		
Me	29b. Signature and title of certifier	1 Clin n	0	29c. License	e number 4 3 /4		9d. Date signed (Mon			
	Pour.				73/7		01000	,		
	30. Name and address of person who comp PANCÎTI IKLUG.	100 %. Car	w11 31	tret, Lel	lis berry	mo. 218	301			
ate rar	31. Date filed (Month, Day, Year)	32. Redistrar's Signal	ture	had						

			For State Registrar	State of Mary		artment of rtificate o			iene _{eg. No.} 2009	07249
			Decedent's Name (First, Middle, Late	st)				2. Date of Deat		3. Time of Death
	Physicia		Mary Rose To	ırner				Februar	y 23, 2009	5:30 a.m.
and,	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town	, or Location of Death		4c. County of Dea	ath
1	Exami		21926 Spring Val	lev Drive		Lexing	ton Park		St. Mary	's
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday)	If Under 1 Yes		8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		220-26-4225	□ M 2 🗓 F	76 Yrs.		, , , , , , , , , , , , , , , , , , , ,	02/07/1	933 Mar	yland
	pu >		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City. Town or Lo	cation				10d. Inside City Limits
	shor	'n			,,					1 ∐Yes 2 X No
	he M	Director	Maryland St. Mary	y's]	Lexington	Park 10f. Zip Cod	ρ	1	0g. Citizen of What C	ountry?
	with t	<u> </u>		1 . D						,
	eath	Funeral	21926 Spring Val	12. Was Decedent Eve	er in U.S. 13.	20653 Was Decedent	of Hispanic Origin? (S		United Sta	
	item item	ᇤ	11. Marital Status 1 □ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 🕅 No			of Hispanic Origin? (S Juban, Mexican, Puert	o Rican, etc.)	Black, Whi	
36	rs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2Xin	No Specify:		Specify: WI	hite
21215-0036	2 hou	Completed	15. Decedent's Ed	ducation		dent's Usual Oc			16b. Kind of Business	
215	in 72	ble	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during most of wor tired)	King		
21	d with giene	mo:	12		Night	Club O	wner		Entertainm	ent
pu	be filed within 72 hours after death with the Marylan tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Welfeal Evaint in trust be retified at	Be (17. Father's Name (First, Middle, Last,)			18. Mother's Nar	ne (First, Middle, I	Maiden Surname)	
/Jai	uld b Ment Ment rrked	10	William Taft Tipp	ett, Sr.			Mary Eth	el Unkle		
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, it in Medical Evalution in the brothing at	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Stre	eet and Number or Ru	ural Route Number	; City or Town, State,	Zip Code)
Σ	and 2 salth n 27 i		John F. Turner/Hu							k, MD 20653
ore	of Hi of Hi fiten		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Domousi from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other p	place)	Date	20c. Location - City of	r Town, State
Ĕ	Pag nent ant: I		4 □ Donation 5 □ Other (Specif		St. Micha	ael's Ce	m. 02/2	7/2009	Ridge, Mar	yland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.		21. Signature of Funeral Service Licer)see	2:	2. Name and Ad	dress of Facility	insfield	Funeral H	lome. P.A.
B	9 2 E 8 9		Edward N. Briff	sfield Jr.	M00052 2	2955 Но			ardtown, M	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	e death. Do not en	ter the mode of	dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Paul	neatro	(0	urol			Onset and Death
1	/Medical		resulting in death)	Due to (or as a c	consequence of):					
	Examiner		Conventially list conditions	b						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):					
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events	c						
ó,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	ate b hysic the bi	dical	•	d						
39	entific ing p	l do	IF FEMALE:							
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Fetal death 3	☐ Ectopic pregn			23d. Date of de Month	elivery Day Year
Ö.	the a	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	me of death 5[Other (specify	")			22,
P.0	d by	Ph	Part II. Other significant conditions	contributing to death but r	not reculting in the u	nderlying cause	given in Part I	23e Did tol	hacco use contribute t	to the cause of death?
Ś.	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death but i	for resulting in the c	ndenying eduse	given in rait i.			Probably 4 Unknown
Records,	e law require has been si ge 2 should b	Completed								
ec	law las b	nple						24a. Was a autops	sy prior to	autopsy findings available completion of cause of
=	The cate I	Son						perform 1 □ Yes		s 2□No
/ita	cian; ertifi ector,	Be	25. Was case referred to medical examiner?	11				ath (Check only on	e)	
£	hysi this o	ဥ	1 Yes 2 No		2 ER/Outpatie	III 3 L DOA		1	ence 6 Other (Sp	ecify)
Division of Vital	ing F	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,)	/ear) 28b. Time o	\ \	njury at Vork?	28d. Describe ho	ow injury occurred	
sio	tend leath tor: /	cati	2 Accident investigatio				1 □Yes 2 □No	DOS Lacation (O		2 1 2 1 1 1 1 1
Ξ	or At fter o pirect in by	E	4 Homicide determined		- At nome, tarm, st (Specify)	reet, factory, offic	ce	City or Town	treet and Number or F n, State)	turai Houte Number,
	urs a urs a eral [One Consider AND Considering D	hysician: To the best of	mu ka awla da a da a	th accurred at th	an time, data and place	a and due to the	nouse(s) and manner	an atatad
	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical		miner: On the basis of each of the basis of the bas	xamination and/or in					
	ithin o the	Mec	29b. Signature and title of certifier	and mariner back		29c. Lic	ense number	2	9d. Date signed (Mor	nth, Day, Year)
	F ≥ F ŏ			man	(1)	1	100557		2/23	119
	D.		20. Nome and address of	completed source of di-	th (Itom 22a) /Tim-		100001	5/	0/00	, , , ,
	44		30. Name and address of person who		,		0 100000	torm M-	wr.1 am 3 20	650
	Sta	te	Jennifer Schmidt 31. Date filed (Month, Day, Year)	32. Fregistrar's		ncs Lan	e, Leonard	LOWII, Ma	гутана 20	650
	Sta Regist		FED 202	4		and I				

DHMH 17 Rev 1/2001

			for State Registrar	te of Maryland		rtment of F tificate of I			giene Reg. No. 200	9 07250
	Physicia /Modis		Decedent's Name (First, Middle, Last) John Henry Tyler					2. Date of Dea Month	Day Yes	3. Time of Death 8:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or	Location of Deat		4c. County of D	eath
	Funeral Director		Washington Adventist 5. Social Security Number 6. Sex 1√2 M 2[7. Age (In yrs. las		Takoma Pa If Under 1 Year Months Days		8. Date of Birti (Month, Day		Birthplace (State or Foreign Country) C
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	cation				10d. Inside City Limits
	Maryl:	tor	DC		ingto					1X∑Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath wi		910 Farragut ST NW Was			20011			USA	
036	thin 72 hours after death with the Maryland e. an "natural", or Items 23a or 28a-f show Modeal Evanding rust be indified at	by Funeral	1 Never Married 2 Married 1 If Ye	Becedent Ever in U.S. led Forces? Yes 2 No les, Give to Dates:		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
15-0036	72 hou	eted	15. Decedent's Education (Specify only highest grade comp.	eted)	16a. Deced	ent's Usual Occup	ation	kina	16b. Kind of Busine	ss/Industry
2	filed within 72 Hygiene. other than "nai ent, in Mulc	Completed		ege (1-4or 5+)	Driv	OO NOT use retired	f)		American F	and Cross
N D	be filed v ntal Hygic ed other t event, th		12th 17. Father's Name (First, Middle, Last)		DIIV	C1	18. Mother's Nar		Maiden Surname)	ted Closs
yland	ο Ο Θ ο	To Be	Benjamin Tyler				Sophia 3	Iohnson		
Mary	s 1 and 2 should be f Health and Menta Item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type. Prin				and Number or Ru	ıral Route Numbe	er, City or Town, State	
e, S	s 1 and of Health item 27 other tr		Denise Tyler/daughter 20a. Method of Disposition			Newton Silicon (Name of	r#204 B1a	densburg	g,MD 20710 20c. Location - City	
банттог	permit. Pages Department of I Important: If ite any Injury or o once.		Burial 2 ☐ Cremation 3 ☐ Removal	cen	Linc	olncemete	ery 2-19-		Brentwood,	
מ	permi Depa Impo any it		21. Signatur of Funeral Service Licensee	ll		Name and Addres	110		Funeral F DC 20011	lome
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. e on each line.	Do not ente	er the mode of dyin	ig, such as cardiae	or respiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis						Chock and Doday
	Examiner			ue to (or as a consequer Cardiac Ar	,					
	p =	ner	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequer						
)	and transi	Examiner	that initiated events c.							
00/00	tificate be executed g physician and as the burial-transit	edical E	d	ue to (or as a consequer	ice of):					
ž	ding pl		IF FEMALE:	o cutoome of prognance						1
.C. BOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director.	Physician/M	in the past 12 months?	s, outcome of pregnanc Live birth 2 ☐ Fetal de Pregnant at time of dea Unknown	eath 3□	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of Month	delivery Day Year
ecords, P	quires that n signed b uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							
Heco	he law red e has bee tge 2 shou	Completed						24a. Was a autops perfor	sy prior med? death	
Z Z	ian: T rrtificat stor, pa	Be C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		es 2K∏No
5	hysic this ce	၉	examiner? 1 Yes 2 No Hospital:	¥XInpatient 2 ☐ EF	3/Outpatient	3 □ DOA Othe	er: 4 🗆 Nursing H	lome 5 Resid	lence 6 Other (S	pecify)
VISION	ending P sath. or: After t he funera	Certification:	1 Actident 5 ☐ Pending investigation	Date of Injury (Month, Day, Year)	3b. Time of Injury	28c. Injun Work M 1 🗆	yat (? Yes 2 □ No	28d. Describe h	ow injury occurred	
Š	Ital or Att rs after d al Direct led in by 1	Certific	4 Homicide	Place of Injury - At home building, etc. (Specify)				City or Tow	n, State)	Rural Route Number,
	he Hospl in 24 hou he Funer pletely fil	Medical	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: Or	To the best of my knowle the basis of examination I manner stated.	ed g e, death n and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	e, and due to the ourred at the time, of	cause(s) and manner date and place, and c	r as stated. due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	<i>i</i>
	3U		PING			11/	0669	40	02/15	12004
			30. Name and address of person who completed	•			112			
	Sta	е	Ping Li 7600 Carrol 31. Date filed (Month; Day, Year)	Ave. Takor 32 Registrar's Signatur	е		114			
	Registra	ar	FFR 1 9 2009	no June 1	bar	Med .				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 17, 2009 2:10 p M **Physician** Lillian M. Traylor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Crescent Cities Adult Medical Day Center Riverdale Birthplace (State or Foreign Country)
 Texas If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. Months 577-48-9032 1 □ M 2 🔀 F Aug. 12, 1921 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Director Riverdale Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number TICA 20737 4409 East West Highway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes **2√X** No If Yes, Give Year or Dates: 1 XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. Black Specify 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) New York City Government Social Service Case Worker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be and Mental Pearl Mabin Samuel Traylor ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 905 Brick Manor Circle, Silver Spring, MD 20905 Tim Traylor/Nephew -lealth Department of Health Important: If item 27 any Injury or other troops. 27 Date 20 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 20, 2009 Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscherotic Candiovascular Disease Physician LAMS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trans and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy

☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Vascular Dementia 24a. Was an autopsy performed has page 1 ☐ Yes 2 ☐ No 1 □Yes 2 → 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊡No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO 1852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) seensburg Rd Hyuttsui 4- MD 20781 DEVUEE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7:54 A^M **Physician** 2 17 2009 Cyprian Olave Tilghman /Medical 4c. County of Death
Prince Georges 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number) **Examiner** Laurel Laurel Regional Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 05/19/1913 Washington, DC 95 577-03-0268 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 No Director MD Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hygiene. Int If Item 27 is marked other than "natural", or items 23a or: USA 20707 7304 Summerwind Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: black ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hotel/Restaurant College (1-4or 5+) Elementary/Secondary (0-12) Local 25 Union President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara M. Humphreys Charles Joseph Tilghman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7304 Summerwind Cir. Laurel, MD 20707 Liz Thorne-Tilghman/wife other 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of important: if any injury or once. Maryland Nat. Cem. 2/24/09 Laurel, Maryland 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility 420 H Street NE Fur val Service 21. Signature BK Henry Funeral Chapel Wash. DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has brieflector, page 2 s autopsy performe 1 ☐Yes 2 X No 1 ☐ Yes 2 🛛 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ∐Yes 2 □ No n 24 hours after death.

Funeral Director: A pletely filled in by the fu 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

within 2

31. Date filed (Month, Day, Year) State FEB 2 3 2009 Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas H. Burguieres, MD Larel ^(3a) (Type, Print) Emergency Dept. 7300 V Larel Regional Hospital, Laurel 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

22966

29d. Date signed (Month, Day, Year)

2009

7300 Van Dusen Road

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 02-26-2009 9:28pM Julia Tolbert Templeton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
10-12-1927 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 81 FAyetteville, PA 202-20-5866 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State i Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD MOntgomery 12516 Galway Drive, Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 12516 Galway Drive by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2√No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other this any Injury or other traumatic event, Its. Once. Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Tolbert Mary Perry ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack R. Templeton 12516 Galway Drive, Silver Spring, MD 20904 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02-28°09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Thomas L. Geisel Crematorium Chambersburg, PA 17202 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas L. Geisel Funeral Home 21. Signature of Funeral Service Licensee M01346 333 Falling Spring Road, Chambersburg, PA, 17202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** hrenic Opostructive /Medical Due to (or as a consequence of) Examiner Dementia Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1∐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier De063748 KOUATCHOU, MD Jocelyne 2-27-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, 201 East University Parkway, Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State MAR 0 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** P^{M} 25, 2009 1909 February Geraldine Amelia Titter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 E1kton Union Hospital Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Min. 1 □ M 2 💢 F Months Days Hours SEPT 12, 1937 Maryland Director 219-34-8807 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 157 Tony's Road 21921 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Thomas Smith Rose Gue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jack L. Titter/Son 1062 W. Old Philadelphia Road, North East, MD 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date February A. Ferris & Co., Inc. 27, 2009 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Diabete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown 9 ☐ Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has e 2 s r this certificate hat ral director, page 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A
id in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled ⊭ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier ပ completed cause death (Item 23a) (Type, Print) Name and address of person wh 111 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician 12:24PM Claudia Volz Lee 2009 ebruary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday) 63 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Days Months 1 □ M 2X F September 8,1945 Florida 215-46-2598 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 ☐ No Director Bowie MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20715 12322 Kemmerton Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No "natural", or 1 ☐ Yes 2 🔀 No Specify: **Maryland 21215-0036** à Specify. 3X Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Management Analyst U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ross Elliott Arline Craven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Lisa M. Scott/Daughter 12322 Kemmerton Lane MD 20715 Bowie, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 2/23/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility 21. Signature of Fun ral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Enter the disease, or como cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final collapso ardiorestrator Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): executed burial-transit attending physician for use as the burial Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. sate has been signed by the page 2 should be detached 9 ☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To funeral c Date of Injury (Month, Day, Year) e Hospital or Attending PI 24 hours after death. e Funeral Director: After the telety filled in by the funeral 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

completely (B)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated

P.O. BOX 297,

29c. License number

Greenbelt, MD. 20770

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per phys. G889 3/19/09 dk

State of Maryland / Department of Health and Mental Hygiene 0 9

Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Zemas 19:47 2009 3 /Medical 4a. Fecility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 66 521-54-3430 Director Nov. 28, 1942 Illinois Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturet", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2X No MD Anne Arundel Severna Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 Heavitree Lane 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1961-If Yes, Give Year or Dates: 1993 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "n any injury or other treumstic event, the Meatl sings. United States Elementary/Secondary (0-12) College (1-4or 5+) Military Officer Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph White Marjorie Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ingrid Lindberg/ Wife 530 Heavitree Lane Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 17, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2009 21. Signature of Funeral Service Scense 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part) Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Coranas **Physician** /Medical Due to (or as a consequence of): Examiner non-Hodg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Chranic Due to (or as a consequence of): 68760 certificate be Physician/Medical use as the Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2010 certificate 1 Yes Vital : After this certifica e funeral director, f Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 2 40 ot 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident filled in by the Director 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct 29a. Certifier 1 Cestifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Dav. Year) D51819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N_{u} Malta 132 Holid らした こい CT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 192009 A. park Registrar

		ı	For State Registrar	State of Mar		artmen rtificate			Mental Hy	giene Reg. No	711119	072	5 7
	Physici	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of De	eath Da	ay Year	3. Time of Deal	
	/Medic		John	Lee		- Wil			2	21	2009	10:34	М
	Examir	er	4a. Facility Name (If not institution, give					ocation of Dea	ath	40	. County of Deatl		
	Funeral		Peninsula Regional 5. Social Security Number 6. S		Center In yrs. last birthday,		isbun 1Year	C Y If Under 24 Hr	s. 8. Date of Bi	rth	Wicomico 9. Birtl	O hplace <i>(State or For</i> untry)	eian
	Funeral Director			XM 2DF	'3 Yrs.	Months	Days	Hours Mir	8. Date of Bi (Month, D	ay, <i>Ye</i> ar, L936		untry) y 1 and	- 3
	ס		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County	1	0c. City, Town or Lo	ocation						10d. Inside City Lir 1 ☐ Yes 2 🛣	
	Ba-f	Director	MD Wicomi	20	Salisb					10 0			140
	with t		10e. Street and Number			10f. Zip				rog. Ci	tizen of What Cor	untry ?	
	ns 23	Funeral	6764 Edward Avenu	12. Was Decedent Eve	arin IIS 13	Was Deced	2180		Specify Ves or N	n- T	USA 14. Race - Amer	rican Indian	
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215-0	within 72 ho lene. • than "natur he Medical	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usua kind of wor DO NOT us	al Occupat rk done du re retired)	tion uring most of w	orking	16b. F	(ind of Business/I	industry	
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	of Health item 27 i		20a. Method of Disposition		20b. Place of Disponentery, cre				Date		ocation - City or 7		
altimore,	ë <u></u> = 5		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemovai from State	<i>cemetery, cre</i> Crematory			i	23-2009	Do.	1mar, De	1 0110 20	
Ħ	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service Licer	<u></u>		2. Name an			Bounds F			taware	
m	Depa Impo any Ir		X Jenes Kel	le barken	7 م	05 E.	Mair					and 21804	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plicatif ns that caused the one of use on each line. a. Due to (or as a control of the control	hing for	rainter the mode		, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death	1
68760,	ificate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):								
	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	□ Ectopic pi □ Other <i>(sp</i>					23d. Date of deli Month	ivery Day Year	
С	res that signed b	by Pt	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	inderlying ca	ause giver	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death	?
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o	ding l h. After funer	tion	1 vatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	(ear) Injury	м	8c. Injury Work? 1 □ Ye	es 2∐No	280. Describe	HOW HIJU	ry occurred		
É	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined			reet, factory,			28f. Location City or To			ral Route Number,	
	the Hospital hin 24 hours a the Funeral I upletely filled	Medical (ysiclan: To the best of entire of the basis of entire and manner state	xamination and/or in								
	Vithi To t	Σ	29b. Signature and title of certifier)	-	290	. License	number		29d. Da	ate signed (Month	n, Day, Year)	
	10 -		,				P6	210/			02/21	109	
	USU		30. Name and address of person who	4	4 (-1	<i>_</i> .					
	- 00-	•	Douglas Wilhi 31. Date filed (Month, Day, Year)	te M.D. 32. Relistrar's		arroll	57.	Sal	sbury	<i>n</i>	11 218	01	
	Sta Registr		EED OO	iono de la	A A	back	J,		1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2-25-09Amend#19b.PerFHPCCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month Physician 20, 3:25 P M Feb. Howard West /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Collington Episcopal Life Care Mitchellville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 26, 1 Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F 93 Connecticut Director 049-01-7038 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygient. Department of Health and Mental Hygient is the man 23a or 28a-f show Important; If finen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Maciforal Examiner must be rediffied. 1 Yes 2 No Director Ipswich MA Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Newbury Road 01938 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1942-14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify þ Specify: White 3 XWidowed 4 ☐ Divorced 1945 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Biostatistician Public Health 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Jacob Weinstein Eve Aleskowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn West - Daughter 33 Newbury Road, Ipswich, 01938 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 2/23/09 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** emendia ud years disease or condition resulting in death) /Medical to (or as a consequence of): Examiner eass carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transi resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 2 300 2 ∑No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the I within 2. 29c. License number 29b. Signature and title of certifier Name and address of person who completed cauth of death (Item 23a) (Type, Print) 54

Registrar

State

CHAMP

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 16, 6:20 am William Benjamin Wheeler February 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Youne 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1912 **Funeral** Months 1**X** M 2□ F 214-03-9146 June 96 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show at 1 ☐ Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified Maryland Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10836 Childs Street 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? ⅓∑Yes 2 □ No If Yes, Give Year or DatesWWII era Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married Ž Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 1 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be John Alfred Wheeler Martha Neale Wallis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Leverenz/Daughter 10834 Childs Street, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark's Episcopal Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 21, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery Silver Spring, Maryland 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2 🗆 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 20 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certi icate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Wheeles, NO; 1116w Vital Records, P.O. Box 68760, 0

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director.

State Registrar

Medical

SH 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

121 MONTRUSE RD 141)

32. Registrar's Signature

(oD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 07260 Certificate of Death Rea. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav CORM Julie Ann Young 27, 2009 Feh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year) Days Months 49 005-66-6437 March 18, 1959 Maine Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ty Yes 2 □ No Harford Aberdeen Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1 West Aztec St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☑ vivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled 12 disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore M. Young Shirley Beasley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 Blythedale Rd., Perryville, MD 21903 Phillip Murphy (brother-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/09 R.A.Ferris & Co. West Chester, PA 22. Name and Address of Facility 21. Signature of Fulleral Service Licensee Tarring-Cargo ind 21001-3399 Funeral Home, P.A. Aberdeen, Maryland anis 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uch as cardiac or respiratory arrest Immediate Cause (Final one hour disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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Funeral

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mydical Expirition must be notified at

is marked other than

Department of Health a Important: If item 27 is any injury or other tra

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altimore, Maryland 21215-0036

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Box

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Division of Vital

Examine burial-tran attending physician for use as the buria Physician/Medical signed by the a I be detached for cate has been signated by page 2 should b Completed certificate funeral director, Be Certification: To After this e Hospital or Attending Pl 24 hours after death. Funeral Director: After the telety filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

2 KER/Outpatient 3 DOA

1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 2 **1**No

25. Was case referred to medical examiner?
1 □ Yes 2 □ No 27. Manner of Death

5 ☐ Pending investigation 6 Could not be determined

Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

1 Natural

2 Accident

4 Homicide

3 🗌 Suicide

📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License numbe

KIVE ISIDE

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY MURTELLO 31. Date filed (Month, Day, Year) MAR 0 9 2009

DHMH 17 Rev 1/2001

State

24 hours a

within 2

completely

		State of Maryland /		rtment of H		and M			009	07261
		Registrar 1. Decedent's Name (First, Middle, Last)	Cer		Jeani		2. Date of Dea	Reg. No.		3. Time of Death
Physic	ian	Joseph Lewis Yates, Jr.				-	Month Februar		2009	2:41 Ам
/Med		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location o				inty of Death	
Exami	ner	St. Mary's Nursing Center		Leonar					St. Ma	ry's
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)	If Under 1 Year	If Under		8. Date of Birt	1	9. Birthp	place (State or Foreign
Director		216-22-2838 ¹іі № 2□F 80	Yrs.	Months Days	Hours	Min.	July 2		B Court	aryland
<u>p</u>		Usual Residence of Decedent					-			
ırylar show	-	10a. State 10b. County 10c. City, To	wn or Loc		4				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ba-f	Director	Maryland St. Mary's		C1eme	ents					
/ith th		10e. Street and Number		10f. Zip Code	_			-	of What Cour	ntry'?
ath v s 23s	Funeral	24425 Coltons Point Road	140.1	2063		-i-2 (Cno	eifu Voo es No		USA Race - Americ	an Indian
er de	ü	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H f Yes, specify Cuba	an, Mexican	gin? (Spe i, Puerto f	Rican, etc.)	1	Black, White,	etc.
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1	□Yes 2X No	Specify:			Spe	ecify: Whi	te
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othe vent,	Be	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name	(First, Middle,	Maiden Surr	name)	
uld be Menta Menta rrked	10 E	Joseph Lewis Yates, Sr.			A	Agnes	Jeanne	ette T	ennyso	n
and I	1		9b. Mailin	g Address (Street	and Numbe	er or Rura	l Route Numbe	er, City or To	wn, State, Zip	Code)
and				Jenny Ly						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is in Suited Examines must be notified at any night or other traumatic event.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Dispos tery, cren	sition (Name of natory or other plac	e)		ate	20c. Location	on - City or To	own, State
Pag ment ant:		4 □ Donation 5 □ Other (Specify) St. Jo	seph'	s Cemetery	1		ry 27,	Morganz	za, Mary	1and
permit, Depart Import any inj		21. Signature of Funeral Service Licensee	22	. Name and Address Mattingley	ss of Facility 7-Gardi	y .ner Fi	uneral Ho	ome. P.A	A.	
	×	Kenneth / Infer		Mattingley P.O. Box 2						
		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dyin	ough as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	our	roma	lox	us				month
/Medical Examiner		resulting in death) Due to (or as consequence)	e of):	4	11/2	/	an	<i>></i>		(10
LXammer		Sequentially list conditions, b.	02	danc	·	NC				-9)
ted	je e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	e oi).							\bigcup
xecur and	Examiner	that initiated events c	e of):							
be estician	dical E									
ficate	gipe	d								
reerti nding use a	Z	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant						23d.	Date of delive	ery
Jeath Jeath Jeath	cial	in the past 12 months? 1 Ves. 3 Ne. 4 Pregnant at time of death		Ectopic pregnanc Other (specify)	У				Month	Day Year
by the	Physician/Me	9 Unknown								
s that	by P	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco use c	contribute to the	he cause of death?
equires een sigr ould be	ed t	A	1				1 🗆 \	es 2□N	o 3 ☐ Prot	oably 4 📆 Unknown
aw re	Completed	Conauttura +	2_	~			24a. Was	an 24	4b. Were auto	ppsy findings available mpletion of cause of
The I	E O	////					perfo	med?	death? 1 □ Yes	
sian: ertifica ctor, p	Be	25. Was case referred to med al examiner?			**	of Death	(Check only o			
hysic his ce I dire			Outpatien	nt 3□DOA Oth	4 (2) 110	ursing Hor	ne 5 ☐ Resid	dence 6 🗆	Other (Special	(y)
ding Pl	ü	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Date of Injury (Month, Day, Year)	o. Time of Injury	Wor			28d. Describe I	ow injury oc	curred	
ttendi death. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home			Yes 2□		207 1 11 11			
or At or At offer of Direct	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	tarm, stre	еет, тастогу, описе		1	City or Tov	n, State)	amber or Hura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of my knowled	dae deat	h occurred at the ti	me date ar	nd place.	and due to the	cause(s) and	d manner as :	stated
24 hc 24 hc Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or in	vestigation, in my o	opinion, dea	ath occurr	ed at the time,	date and pla	.ce, and due to	o the cause(s)
ompl	Me	29b. Signature and title of certifier		29c. Licens	e number			29d. Date si	gned (Month,	Day, Year)
FSFO		bannast bankos	-M	1 5	Obl	119		2 -	23-	09
Im		30. Name and address of person who completed cause of death (Hem 23)	a) (Type,	Print)		1				-
10	1			Three Not	ch Ro	ad 1	Hollywo	od, MI	20636	5
s	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1							
Regis	trar	31. Date filed (Month, Pay, Year) FEB 2 3 2009	140	New York						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Doris Lucille Zeller February 19, 0215 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Manor Health Care Center Rising Sun r 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XXF 214-22-3159 80 Oct. Maryland Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Cecil Port Deposit 23a or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 50 Devon Drive 21904 U.S.A. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give , or items 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 💢 X√lo Specify þ White XX Widowed 4 ☐ Divorced Year or Dates: "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Personal Residence 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th Twelve Years or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland A. McCubbin lda Lucille Lambdin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any injury or other trau Linda Z. Stratton (Daughter) 50 Devon Drive, Port Deposit, 21904 Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 02/22/09 | West Chester, Pennsylvania 4 ☐ Donation 5 Other (Specify) 21. Signafure of Funeral Service Li 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed as the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?

1 Yes No
9 Unknown 3 Ectopic pregnancy for 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manuar of Deal 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After Natural Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760. Division or Vital Records, P.O.

2

State Registrar

Medical

31. Date filed (Month, Day, Year)

and title of certifier

30. Name and address of person who complete

(Check only one)

29b, Signatu

32. Registrar's Signature

pause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

200

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alexander, Jr. George 2009 1:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Spa Creek Nursing & Rehab. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth . Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** X M 2 F Months Days Hours Min. JUL 7 1950 029-40-7553 58 Massachusetts Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shore 1 Yes 2 No Completed by Funeral Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 21403 USA 3242 Blackwalnut Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: 1967–70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Elementary/Secondary (0-12) College (1-4or 5+) State Lottery Computer Technician Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental Ith and Mental 27 Is marked of traumatic ever Alexander George W. Doris LaFrance ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Lenore R. Alexander - wife 3242 Blackwalnut Drive, Annapolis, Maryland 21403 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tronge. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc.03/09/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Streven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) onic cavainoma **Physician** Yeavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 1 ☐ Yes 2**3** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Physician 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestowe Rd. selonicu, uo 31. Date filed (Month, Day, Year) Registra

21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 07264 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:56 AM 03 Marie Adelung 20 Lois /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Lord Samantan Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖫 F 220-36-6463 Director Oct.3,1943 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at MD Baltimore Essex Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Essex Avenue 21221 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wise R. Edwards Thelma Ogle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steadman Adelung /husband 403 Essex Avenue Baltimore MD 21221 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial / ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/11/09 Belair Memorial Belair MD n 5 ☐ Other (Specify) Funeral Strvice Lion see 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Out to (or as a consequence of) Sequentially list conditions, if any, leading to min educt cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No Asthic 1 □Yes Cteroso 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar DHMH 17 Rev 1/2001

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Keg - 200

29d. Date signed (Month, Day, Year)

03-08-2009

09-01916	
Curtis Amburgev	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 07265

		1- For State Certificate of Death Reg. No.									
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Curtis Wayne Ambu	rgey, Sr.				2. Date of Death Month March 7, 2	Day Year 009	3. Time of Death 1315 hrs		
		4a. Facility Name (if not institution, give St. Agnes Hospital	street and number)		4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of N			
Funeral Director		<u></u>	7. Age (In yrs. las	t birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1		9. Birthplace (State or Foreign Country)		
any.		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Locat	tion	_			10d. Inside City Limits		
8 . l	tor	MD Baltim	ore			horpe		g. Citizen of Wha	1 Yes 2 No		
with the Maryland ms 23a or 28a-f she be notified at once	Director	10e. Street and Number 4507 Linden Avenu	e		10f. Zip Code 212	227			States		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shounatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced 15. Decedent's Education (Specify on)	or Dates:	1	as Decedent of Hispa res, specify Cuban, I res 2 No nt's Usual Occupatio	Mexican, Puerto I	Rican, etc.)	14. Race - White, Specify: 16b. Kind of Busi	White		
36 nin 72 hou e. than "nati dical Exa	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	nost of working life. E er Mechar	NOT use retire			ontractors		
D 21215-0036 should be filed within 72 hou and Mental Hygiene. 7 is marked other than "mate natic event, the Medical Exa	Be Com	17. Father's Name (First, Middle, Last) Gaines R. Amburge	у			Mother's Name Dora Le	e Brown	aiden Surname)			
MD 21 od 2 should other and Me on 27 is man	2	19a. Informant's Name/Relationship (Ty Tracey Musick - F	riend	4507	g Address (Street a	Wenue,					
Baltimore, MD 2 permit, Pages I and 2 shou Department of Health and I Important: If item 27 is ninjury or other traumatic		20a Method of Disposition 1 X Burial 2 Gremation 3 4 Donation 5 Other Specify:	Removal from State Meä	dewrid	Dork	3-1	Date 3 - 2009	Flkrid	oity or Town, State		
Balt permit Departi Import		2) Sign with of Euner II Service Licens	* DAH	22. 1	Name and Address of Sulphu	of Facility Amb or Sprin	rose Fu	neral Ho Arbutus.	me, Inc. MD 21227		
Physician /Medical xaminer	e a	23a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause time disease a. Multiple Injuries									
xaor		or condition resulting in death) Sequentially list conditions, b.	Oue to (or as a consequence of):								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Oue to (or as a consequence of): Oue to (or as a consequence of):						·		
1760, ficate be executed g physician and s the burial - transit		d.						_			
O, e be ex sician burial	n/Medical	UNPENDED	AMENDED					Tool By (
Aecords, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnation Live birth 4 Pregnant at time of deal 9 Unknown	2 Fe	etal death 3	Ectopic pregnat	ncy	23d. Date of d Month	elivery Day Y ear		
P.O. I es that the signed by the detache		Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause giv	en in Part I.			ute to the cause of death? Probably 4 Unknown		
Division of Vital Records, P.C tal or Attending Physician: The law requires that its after death. **I Director: After this certificate has been signed led in by the funeral director, page 2 should be deta	Completed by						24a. Was a autops perform	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?				of Death (Check o	nly one)				
of Vital Fing Physician: After this certifications and are the control of the certification o	To E	1 Yes 2 No	ospital: 1 Inpatient 2 🗸 E					Residence 6	Other:		
ion of tending Pheath.		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	Mar 7, 2009 Yeár)	28b. Time of 1258 hrs		at Work? es 2 ✓ No	28d. Describe h Motorcyclist	ow injury occurre collided wi	th car		
Division ital or Attenurs after death ral Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor		et, factory, office bui			treet and Number ate) ens Avenue, Ba	or Rural Route Number, City		
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical C	29a. Certifier 1 Certifying Physicia	an: To the best of my knowledge On the basis of examination and and manner stated.	e, death occu d/or investiga	rred at the time, date	e and place, and death occurred a	due to the cause the time, date a	e(s) and manner a and place, and du	e to the cause(s)		
F 3 F 8	Me	29b. Signature and title of certifier	Moule		29c. License O.C.M			29d. Date signed March 8, 20	i (Month, Day, Year) 09		
		30. Name and address of person who command Margarita Korell MD. As:	ompleted cause of death (Item 2 sistant Medical Examine		enn Street, Ba	Itimore, MD 2	21201				
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. registrar's Signature	ba	west .						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07266 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 5:32 Murch 2009 4b. Cjty, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Hospita Baltimore N/A Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days 1 □ M 2 🕱 F DEC 24 1934 MARYLAND 212-32-5119 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1XXes 2 □ No BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1219 N. AUGUSTA AVE. 21229 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XXIo Specify: BLACK 3 ☐ Widowed 4 X 10 ivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) 12yrs 2yrs PARA PROFESSIONAL PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK QUEEN ELIZABETH AMBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda D. Ross/Daughter 3046 Grantley Ave., Baltimore, Md., 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 03-14-09 BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1206 W NORTH AVENUE 23a. Part 1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Lanurs

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Musical Examinar must be redified at any injury or other traumatic event, the Musical Examinar must be redified at any bines.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760, 🖟

	resulting in death)	u.	VIVI I	at a di Cillan			C 404.2
	1	Due to (or as conseq	10	Disease			30 4000
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uence of).	1)(364)			30 9647
	resulting in death) Last	Due to (or as a conseq	uence of):				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □Unknown	23c. If yes, outcome of pregnance 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 🗆 Ectopic		,	23d. Date of de Month	elivery Day Year
ğ	Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlying	cause given in Part I.			o the cause of death? Probably 4 Tonknown
Completed					24a. Was an autopsy performed′ 1 □ Yes 2 🗗	prior to death?	utopsy findings available completion of cause of s 2 \(\square\) No
Be (25. Was case referred to medical			26, Place of De	eath (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	©ER/Outpatient 3 ☐ I	OOA Other: 4 I Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	ecify)
Certification: To	27. Manner of Death 17⊈Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or F ate)	lural Route Number,
Medical (29a. Certifier (Check only one) 2 Medical Exam	yslcian: To the best of my knoniner: On the basis of examinated and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
ž	29b. Signature and title of certifier	/	2	9c. License number	29d. l	Date signed (Mon	th, Day, Year)
	> Nowalm ya	cypych mp	4	0052022	Ma	rch 7	2009

State Registrar

Yaynych MO Harber Hospital 32 Registrar's Signature 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 South Hanove-Street Baltimore Maryland 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01819 State of Maryland / Department of Health and Mental Hygiene 07267 Robert W. Bond Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0220 hrs March 3, 2009 Medical Examiner Robert W. Bond 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham Doctors Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Massachusetts

Nov. 7 1959 Country) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours 1959 Nov 7. Director 49 1 X M 2 F 020-46-5356 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 Yes 2 X No or 28a-f show Prince George's Bowie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at 20716 14904 Nighthawk Lane Z3a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Armed Forces death 1 Never Married Married Yes Black Specify: Yes 2 X No specify: f Yes, Give Year 3 XWidowed Divorced hours after "natural". þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Heafth and Mental Hygiène. traumatic event, the Medical 21215-0036 Jeweler Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Thelma Pierce Be James Carleton Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14506 MacBeth Drive Silver Spring, Maryland 20906 ce of Disposition (Name of cemetery, Date 2000: Location - City or Town, State <u>R</u> Arlene Bond, Sister item. 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) : If it Burial 2 X Cremation 3 Removal from State 03/10/09 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify 21. Signature of Funeral Service Insec Thomas Gregor ²² Name and Address of Facility
Cremation Society Of Maryland, Inc
299 Frederick Road Baltimore, Mary 21228 and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line Death Medica Complication of renal disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a, PII, 27, perME, g889 3/13/09 TT Physician/Medical X UNPENDED led by the attending physician detached for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IE FEMALE Year Month Day 23b. Was decedent pregnant in the Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown Ś Hypertensive cardiovascular disease Completed 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of autonsy death? performed? No Yes 2 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director; 25. Was case referred to medical Division of Vital å Other₄ Other Hospital: 1 / Inpatient 2 DOA Nursing Home 5 ER/Outpatient 3 ို 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) Registrar **ORIGINAL**

1 - For State Registrar

Physicia	an	1. Decedent's Name (First, Middle, Last)		7					Month Day Year March 6, 2009			
	Medical								4c. County of		7:00 A M	
Examin	er	2301 Bauernschmid			40. City,	Esse		1	Balt:		2	
Funeral		5. Social Security Number 6. Sex		yrs. last birth	day) If Under	1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birthpla	ice (State or Foreign	
Director		213-32-4877 ¹ \(\text{M}\) M 2	□F	73 Y	rs. Months	Days	Hours Min.	Dec 28,	1935	Countr Mary	yland	
D .		Usual Residence of Decedent										
arylar show	_	10a. State 10b. County	100.	City, Town						100	d. Inside City Limits 1 ☐ Yes 2 🛣 No	
Ba-f:	ecto	Maryland Baltimore		LS.	sex	0-1-						
with th	ä	10e. Street and Number			10f. Zip		1221		10g. Citizen of What Country? USA			
s 23	Funeral Director	2301 Bauernschmidt Di	s Decedent Ever i	nIIS	13 Was Deced			pecify Yes or No-			n Indian	
fter d r Item iner.	ᇤ	1 Never Married 2 Married	ned Forces?]Yes 2[X]No				ispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		White, et	c.	
al",o	b	3 ☐ Widowed 4 ☐ Divorced If Ye	es, Giv <i>e</i> ** ar or Dates:		1 □ Yes 2	2 X No	Specify:		Specify:	Whi	te	
72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a.	Decedent's Usua Give kind of wor	al Occup	ation during most of wor	king	16b. Kind of Bus	iness/Indu	istry	
ithin ne. han "	d d		llege (1-4or 5+)				during most of wor 1)		Rest	aurai	nt	
led w Hygie her ti nt, in	ပိ	17. Father's Name (First, Middle, Last)			Manage	21	19 Mother's Nan	ne (First Middle	Maiden Surname,			
ntal Hed of	Be	Louis Banaszkiewic	7						a Sobczynska			
houtch Me Me Me Mark	ဥ	19a. Informant's Name/Relationship (Type. Pri		195	Mailing Address	(Street	and Number or Ru		,	tate Zin (Code)	
id 2 s Ith ar 27 is trau		Helena Banaszkiewic					hmidt Dr		-			
s 1 ar f Hea item other		20a. Method of Disposition	20		Disposition (Nan crematory or o			Date	20c. Location - C			
Page: lent o nt: If		1 ☐ Burial 2 X Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)					nc. 03/	06/09	Baltimo	re.	Maryland	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment for rottled at once.		21. Signature of Funeral Service Licensee		70.010								
B a L De		Thomas Gregor	-		299 F	rede	ss Society rick Roa	d Baltim	ore, Mar	ylan	d 21228	
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the d	ieath. Do n						í	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	hours	0	Sitre	Ail	se Put	MISHORE	10,100)	Pi	Onset and Death	
/Medical		Immediate Cause (Final disease or condition resulting in death) a. Charic Obstructive Pilmisnery Disease is year Due to (or as a consequence of):										
Examiner	_	Sequentially list conditions, b										
ted nsit	Examiner	riany, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury										
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death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical	IN FEMALE.										
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w requires that the d s been signed by the should be detached	Phy	9 Unknown	ag to dooth but not	reculting in	the underlying o	auca civ	on in Part I	23e Did to	bacco use contrib	oute to the	cause of death?	
res the signe I be d	þ	Part II. Other significant conditions contributi	ng to death but not	resulting in	the underlying G	ause giv	en in Pari I.	1 Z Y			bly 4 Unknown	
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n: Th ficate r, pag								1 □ Yes	2 No 1		2 □No	
sicial certi recto	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	l:	0 T FD/0		Oth	or:	ath (Check only or				
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nding tth. :: Afte	tio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	(r) In	jury M	Worl	k? Yes 2 □No					
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tal or s afte al Dir ed in	Certification:	4 Tromode	building, etc. (Of	Jediy)				City or Tow	n, State)			
To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only 1 Certifying Physician 2 Medical Examiner: C										
the Ithin 24	Medical		nd manner stated.		200	Lloons	e number		29d. Date signed	(Month D	lay Vaari	
7 × × 10 0	-	29b. Signature and title of certifier	De .		()	. Licens	27 CT	7 '	29d. Date signed	/ \	Ay, rear)	
		20. Name and address of parent who	d course of doort	(Itom 22a) (Time Print	H	2229		2/6	1/2	209	
		30. Name and address of person who complet	Lause of death	24	Ma ce	An	w. Ba	Himm	- MI))	1221	
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	ignatur	Back	2	,	(V///- CO/ \			109	
Registr	ar	WAR 1 0 2009	Aura	p.	Forman State of the State of th							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

DHMH 17 Rev 1/2001

09-01853

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dam Buck		1- For State Registrar	State	e of Maryland		ment of icate of		nd Ment	al Hyg		g. No.	200	9 07	26
Physicia Medical Examir		Decedent's Nam Adam	e (First, Middle,L Buck	ast)			·· -	,	200	Date of Death Month March 5, 2	Day	Year	3. Time of Death 0848 hrs	1
		4a. Facility Name (i		give street and number)		4	b. City, Town, c	r Location of		·		unty of Death		
Funeral Director		5. Social Security N 216-71-00	Number 6.		ie (In yrs. last I	birthday) Yrs.	If Under 1 Ye Months Da		1 46-	3. Date of Birt	h(MM/DD/\	YYYY) 9. Birt	nplace (State or number) MD	
ruy.		Usual Residence of 10a. State	f Decedent 10b. County		10c. City, To	wn or Location	on	•					10d. Inside City I	Limits
Maryland 28a-f show any d at once.	٦	MD	Harfor	d	Edg	gewood	1						1 Yes 2	X No
n with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Nu		ge Court			10f. Zip Code 21	.040		10	g. Citizen o	USA	try?	
hours after death 'natural'', or ite Examiner must	ted by Funeral	11. Marital Status 1 X Never Marria 3 Widowed 15. Decedent's Ed	4 Divorce		No No	If Ye	Decedent of Hes, specify Cuba Yes 2 X N 's Usual Occupa st of working life	on, Mexican, specify:	Puerto Ric	can, etc.)	Spe	White, etc.		-1
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		4 Donation 5	X Cremation :	ify:	Metro	o Cren		Inc.	03/09		Balt		, MD	
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Physician /Medical Examiner			ly one cause on Final disease	mplications that caused each line. a. Dilated c Due to (or as a cons	ardiom	not enter th							Approximate In Between Onse Death	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	≥	IF FEMALE: 23b. Was decedent past 12 months	?	1 '	me of pregnan	2 Fet	al death 3 er (Specify)	Ectopic	pregnancy	/	23d. Da Mor	ite of delivery	ay Yea	r
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Divis To the Hospital or At within 24 hours after d To the Fuueral Direct	edical	one) 2 🗸	Medical Examin	ician: To the best of m ier:On the basis of exal and manner stated.			on, in my opinio	n, death occ						
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		30. Name and addre Donna M. V		o completed cause of d Assistant Medic		-	Penn Stree	t, Baltimo	re, MD	21201				
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DHMH 17 Rev 1/20	_	MAR	1 0 2009	June	/	DICINAL								

OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 .Month **Physician** : 20 PM 1arc /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 306 NI Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 M 2 □ F Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, I've Medical Examiner i sast be rediffed at 1 Nes 2 No Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 þ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Shoreman Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ mms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore - daughter Aue Koxanne TYIO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any Injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 109 saltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Honce Brehms Batto MiD 21213 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 12 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) ad title of certifier 29b. Signature March ofth M.(1) Name and address of person who completed cause of death (Item 23a)/Type, Print)

NUD Min (M. D.) 9114 Philoadyphia Road # 806, Balfimore Min(M.D. 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** mary 4:20 A M 03 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVERDALE PG CRESCENT CITIES CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Days 1 □ M 2 🕪 578-28-960 October 18, 1918 North Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth end Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. or items 23a or 28a-f show 1 Nes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 2073 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 □ Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ №6 ģ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LnKnawn nown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holloway Michael -Uruardian 21202 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremetion 3 Removal from State 09 1 to more 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howell 4600 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final OLON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or es e consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, HYPERTEN SION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 □ Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Division** Natural 2 Accident 5 Pending investigation ours after death. leral Director: A filled in by the fu 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 4409 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

00064208

WEST HWY RIVERDALE MD 2073

		-	For State Registrar	tate of Maryland		riment of H tificate of L		nentai riyg Re	g. No. 2009	07272
	Physicia	an.	1. Decedent's Name (First, Middle, Last)			-		Date of Deatl Month	Day Year	3. Time of Death
	/Medic		Carolyn J. Barn					March	7, 2009	6:52am [™]
	Examin	er	4a. Facility Name (If not institution, give street	,		4b. City, Town, or			4c. County of Death	
.*1			Carroll Hospital C	7. Age (In yrs. last	hirthday)		inster If Under 24 Hrs.	8 Date of Birth	Carro	
	Funeral Director		218-36-0442 ^{1□ M}		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 15	Year) Cou	nplace (State or Foreign untry) MD
	tud.		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits
	Maryla -f sho	tor	MD Carroll		om or 200		sville			1 □Yes 2X No
	n the	Director	10e. Street and Number			10f. Zip Code		11	g. Citizen of What Cou	intry?
	th wit	la l	305 Obrecht Road			217	84		USA	
	r dea	Funeral	11. Wallal Status	Vas Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show viteal Examinational be notified at	<u>چ</u>	T45.	l ∐Yes 2)∑ No fYes, Give ∕ear or Dates:	1	□Yes 2 X □No	Specify:		Specify: Wh	nite
15-0036	72 hou	Completed	15. Decedent's Educatio (Specify only highest grade co	n 1	6a. Deced	ent's Usual Occupa	ation Juring most of work	ina	6b. Kind of Business/l	ndustry
2	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 Is marked other than "natun other traumatic event, in a Modical	m Ag		College (1-4or 5+)		kind of work done o		9	01 .	1
2	lled w Hygie Iher tl		17. Father's Name (First, Middle, Last)		Exec	cutive Se	cretary 18. Mother's Name	- /First Middle N	Clerica	11
an	d be f ental I red of c eve	Be	Harry F. Schmid	t.				M. Gebei		
Ž	2 should be filed v n and Mental Hygie Is marked other t raumatic event, in	၉	19a. Informant's Name/Relationship (Type. I		19b. Mailing	g Address (Street a			City or Town, State, Z	ip Code)
Š	and 2:		Mrs. Michele R. Ridg	ely ely	305 ()brecht_R	oad Sykes	sville. N	ID 21784	
e,	es 1 a of Her fitem		20a. Method of Disposition	20b. Plac		sition (Name of atory or other place			20c. Location - City or T	own, State
Ĕ			1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	•	Mem. Gar	1	3/09 1	Marriottsvi	.11e, MD
Baltimore, Maryland 2121	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	6. 1+ 110-171	HA HA	Name and Addres AIGHT FUN Box 195	s of Facility ERAL HOME	Е & СНАРІ	EL, PA	
			23a. Part 1. Enter the disease, or complication	ons that caused the death. I						Approximate
44	Physician		shock, or heart failure. List only one ca Immediate Cause (Final	ause on each line.	_	narj	E (145		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen		nur	1-14)	614)		
	Examiner		Sequentially list conditions b. —							
	sit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):					
•	xecuti and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	ice of):					
68760	ifficate be executed g physician and as the burial-transit	edical E	d.							
	ntifical ng phy as th	Medi	JE EENALE.							
Box	death cer e attendin d for use	an/N	Zob. Was decedent pregnant	f yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de	y eath 3□	Ectopic pregnancy	,		23d. Date of deli	very Day Year
O.	w requires that the death certific been signed by the attending p should be detached for use as	hysician/M		4 ☐ Pregnant at time of deat 9 ☐ Unknown	th 5□	Other (specify)			Mond	Day Teal
J.	requires that the peen signed by th hould be detache	Δ.	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds S	quires n sigr uld be	ed by	ASCVD	Status,	pust	CAK	6	1 □ Ye	s 2 No 3 Pro	obably 4 Unknown
Vital Records,	aw rei	Completed		(24a. Was ar	24b. Were aut	topsy findings available ompletion of cause of
ř	iician; The law certificate has b rector, page 2 sl	mo						autops perforn	ned? death? □No 1 12 Yes	2 No
Ita	cian; ertific	Be	25. Was case referred to medical examiner?				26. Place of Deat			
<u></u>	hysik this o	၉	1 Yes 2 No Hosp	1 Inpatient 2 DEH		t 3 □ DOA Othe	4 LI Nursing Ho		nce 6 ☐ Other (Spec	eify)
Division of	ding F	ion	1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day, Year)	b. Time of Injury	28c. injury Work M 1 □	rat ? /es 2 □No	28d. Describe ho	w injury occurred	
18	Atteno death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At home	e, farm, stre		162 2 1140	28f. Location (St	eet and Number or Ru	ral Route Number,
2	tal or r rs after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)				City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		an: To the best of my knowle On the basis of examination and manner stated.						
	To the within To the compl	Me	29b. Signature and title of certifier	1		29c. License	number	2	9d. Date signed (Month	ı, Day, Year)
)	1		000	4436	2 (03/09/	2009
			30. Name and address of person who comp	eted cause of death (Item 23	3a) (Type, F	Print)	1.1		WESTMI	NSTER_
				eted cause of death (Item 23	200	NEMOR	JAL AV	enve	MARYLA	ND 21157
	Sta Registr		31. Date filed (Month, Day, Year)	2. negistrar s signature	box					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Clarence Joseph Bunch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington Hospital Center Hagerstown 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, Dec 16, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Year) 1963 ^{nt}AL 45 Director 214-82-5081 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirar must be notified at MD Washington Hagerstown 1 □Yes X□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1184 Wayne Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary KayDraggee Clarence Eugene Bunch ပ 19a. Informant's Name/Relationship (Type. Print)
Mrs. Mary Bunch (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1184 Wayne Avenue Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State True Gospel Cemtery 4 ☐ Donation 5 ☐ Other (Specify) 3/12/2009 Lisbon. MD 21. Signature of Funeral Service Licensee Name and Address of Facility IGHT FUNERAL HOME & CHAPEL, P Box 195 Sykesville, MD 21784 160764 PO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ulmonory /Medical Due to (or as a consequence if): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsugaence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte d be detached for Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ cate has been si page 2 should b 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 410 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Gr. Koilpil Walnut 4(02 31. Date filed (Month, Day, State Registrar

29b. Signatura a

29c. License number

DOUS7285

29d. Date signed (Month. Day, Year)

2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 2009 ariori /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Himore Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 11/12/61 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days 1 XM 2 ☐ F 47 212-84-5357 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amountant: or other traumatic event, the Wedgel Evander, and the molified anone. N/A MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21212 501 E. Preston St. usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Specifyfrican Baltimore, Maryland 21215-0036 1 □Yes 2 🕍 No Specify \$ 3 Widowed 4 Divorced American Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vivian Branch Marion Ford မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Branch/Mother 1076 Cameron Rd, Balt., MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 3/14/09 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Balt., MD Louden Park Cem 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Hari P. Close F. Svs 5126 Belair Rd,Balt.MD 21206-5105 21. Signature of Funeral Service License, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Candiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardio myopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ettending physician and for use as the burial-transil P.O. Box 68760, The resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached it Division of Vital Records,

examiner?			and the state of t									
examiner? 1 Yes 2 □ I	No	Hospital:	1 ☐ Inpatient 2	ER/Outpatient	3 🗆 🛭	OOA Other: 4 Nursing I	sidence 6 Other (Specify)					
27. Manner of Death 1 Natural 2 Accident	5 Pending investigation	1	Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c. Injury at Work? 1 □Yes 2 □No		e how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of Injury - At building, etc. (Spe		t, facto	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		niner: On						ne cause(s) and manner as stated. e, date and place, and due to the cause(s)				
OCL Cinnature and	itle of contifier				0	Oo Lineage number		20d Data signed (Month Day Your)				

D250

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 N. worfes Balto, MD 21287

Year

:27 AM

Birthplace (State or Foreign Country)

Svs, PA

Day

2 No

Year

Approximate Interval Between Onset and Death

minutes

10d. Inside City Limits

ty∑Yes 2 □ No

MA hN O(N

31. Date filed (Month) Day, Year)

WAR 1 0 2009

Medical

State

Registrar

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 8:45 AM David Evan Buswell 2009 March 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex XXM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 21,1955 Birthplace (State or Foreign Country) **Funeral** Days Months Director 216-62-5793 53 Sept. Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Widdon Evandor, and be putilled as Director Maryland N/A Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3980 Edgehill Avenue F6 21211 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Armed Forces: 1 XYes 2 No If Yes, Give Year or Dates: Vietnam filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Site Engineer Comcast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be filealth and Mental F Holt W. Buswell Katharine Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katharine Buswell Sloat Sister 1450 Redfern Avenue, Baltimore, Maryland 21211 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/9/2009 Glen Burnie, Maryland 4 □ Donation 5 ☐ Other (Specify) 21. Signatule of uneral Service License 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Yeart failure. List only one cause on each line. 3631 Falls Road, Baltimore, Maryland Approximate Interval Between Onset and Death 14 days Immediate Cause (Final disease or condition SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days OSTEOMYELITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Endocarditis as the burial-tran and Due to (or as a consequence of) P.O. Box 68760. attending physiciar death certificate be Pneumonia days MRSA Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the a ☐Yes 2☐No 9 Unknown 9 I Unknown signed by t the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Within 24 hours after death.

To the Funeral Director: After this certificate has to completely filled in by the funeral director, page 2 s 24a. Was an autopsy performed? Yes 2 X No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 💢 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EZINMA ACHEBE MD UNION MEMORIAL HOSPITAL, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

JAMES BURGEE

physician as the burial-1 Division of Vital Records, P.O. Box 68760, attending pl After this certificate has been signed by the afuneral director, page 2 should be detached After this or Attending within 24 hours after death To the Funeral Director: To the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f st Examiner must be notified

Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner my

uth and Mental h

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any In]ury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examine

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

2:30 а.ш.

2009

MARCH

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not resulting in t	the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	Jaanitali		Death (Check only one)	
TO TOO EMITO	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 □ DOA Other: 4 □ Nursi	ng Home 5 🗌 Residence	6X Other (Specify) HOSPICE
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Tir Inju	me of ury Mork? M 28c. Injury at Work? 1 🗀 Yes 2 🗆 No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examle one) X Nurse Pract	sician: To the best of my knowledge, oner: On the basis of examination and/	death occurred at the time, date and poor investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certhier	earp	29c. License number	2 29d. D	ate signed (Month, Day, Year)
30. Name and address of person who co	, , , ,			
JACKIE JONES, CRI			LUM, MD 21093	
31. Date filed (Month, Day, Year) NAR 1 0 20	32. Rysistrar's Signature	face		

State

Registrar

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of h ertificate of		Mental Hy	giene Reg. No 2	009	07277
	Discolati		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
	Physicia /Medic		MARY VIRGI		BISCHER	T		MARCH	9,200		5:20 a M
7,	Examin	er	4a. Facility Name (If not institution, give s 1929 E. PRATT				r Location of Death	1	4c. Cou	inty of Death N/A	
	Funeral		Social Security Number 6. Sex		(In yrs. last birthday		If Under 24 Hrs. Hours Min.	(Month, Da	rth av. Year)	9. Birth	place (State or Foreign
	Director		217-30-3348 1LL Usual Residence of Decedent	M 2 ∑ F	74 Yrs.	Wienwie Baye		FEB. 9	1935	MA	RÝLAND
	yland Now		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	e Mar Ba-f sk	ctor	MD N/A		BALTIM						1 XYes 2 No
	with th	Dire	10e. Street and Number	CMD FIRM		10f. Zip Code	224		10g. Citizen		•
	items 23	Funeral Director	1929 E. PRATT	STREET 12. Was Decedent E	ver in U.S. 13.	Was Decedent of H		pecify Yes or No	o- 14. i	U.S.	ican Indian,
980	be filed within 72 hours after death with the Maryland ntal Hygiene. In the matural", or items 23a or 28a-f show event, the Medical Examitive must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1	0	If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Puerti Specify:	o Rican, etc.)	1	Black, White, ec <i>ify:</i> WI	etc. HITE
5-0036	72 hou natura	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	edent's Usual Occup kind of work done	during most of work	kina	16b. Kind o	f Business/Ir	
2121	within iene.	mple	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retire	d)	g	MANUF	ים <i>ר</i> ידוויים מי	RING
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		271	БОКЫК	18. Mother's Nam	ne (First, Middle			XING
/lan	should be filed vand Mental Hygis s marked other umatic event, II	To Be	JOSEPH JOHNSO	N			NAOMI	RODE	EHEAVE	S	
Maryland	2 sho and r is ma		19a. Informant's Name/Relationship (Type		1	ing Address (Street					
d'	is 1 and 2 should of Health and Mer item 27 is marker other traumatic		WILMA BISCHER/ 20a. Method of Disposition	DAUGHTER		9 E. PRA osition (Name of matory or other place)		EET, BAI		E, MD.	
Baltimore,	it. Pages rtment o rtant: If njury or		1 Burial Cremation 3 R 4 Donation 5 Other (Specify)		BAYVIEW	CREMATO	ORY 3/12				, MARYLAND
Bal	Depa Impo any I		21. Signature of Funered Service License			2. Name and Addre LTLLY & 1901 EAS	ZEILER STERN AV	INC. F	TUNERA BALTIM	L HON	ME MD. 21231
П			23a. Part 1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	cations that caused t e cause on each inc	he death. Do not er	ter the mode of dyi	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
Andrew .	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	KOL					year
	Examiner		Daniel Market and Millian	540 to (01 45 4	de la constante de la constant						
	ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
6	execut and al-tran	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence of):						
68760,	ficate be executed physician and s the burial-transit	edical F	€ d	•					_		
_	ertifica ling ph e as th	Med	IF FEMALE:								
O. Box	The law requires that the death certificate has been signed by the aftending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	гу		23d.	Date of delive Month	very Day Year
ъ,	uires that the de signed by the a d be detached i	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the u	underliying cause giv	ven in Part	23e. Did	tobacco use c	ontribute to	the cause of death?
ord	w require been sign	ted	Kroni Clas	Mille	i They	mend	MIROL	7 1	Yes 2 □ N	o 3 Pro	bably 4 Unknown
Records,	ıelaw ⊁hasb ge2sk	Completed						24a. Was auto	an 24 psy ormed?	b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital	iclan: The certificate ha		25. Was case referred to medical				26. Place of Dea	1 □Yes	2 No	1 🗆 Yes	2 □ No
f Vi	di is	To Be	examiner?	ospital: 1 Inpatien	nt 2 ER/Outpatie	nt 3 DOA Oth	er.	ome Resi		Other (Spec	ify)
n of	ng offe	on:	27. Manner of Death ↑ Natural 5 Pending	28a. Date of Injury (Month, Day,	y 28b. Time of Injury	Wor		28d. Describe	how injury occ	curred	
Division	Attending or death. ector: Afte by the fune	icati	Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	ry - At home, farm, st		Yes 2□No	28f Location /	Street and No	imber or Rur	ral Route Number,
Ωį	al or A s after il Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	reet, tactory, emoc		City or To	wn, State)	imper or riar	ar rioute rumber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir		examination and/or in						
	To the withir Comp	Me	29b. Signature and title of certifier	18	110	29c. Licens	se number	,	29d. Date sig	ned (Month,	Day, Year)
	(Mr-Shy	Alm	10	0-	-1015	/	Man	ch 1	0, 2001
	K		30. Name and address of person who co				CHTET	100 ===	· m		21222
	Sta		CHI-SHIANG CHEN 31. Date filed (Month, Day, Year)	2. Registrar	r's Signature	AUL PL.	SULTE 4	aug, BAI	T.T.MOE	E, MD	21202
	Registr	ar	MAR 1 0 2009	Receive	S. par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JOHN CALVIN BEERS /Medical 2009 4c. County of Death MARCH 4 7:48 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HTLT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number Funeral X M 2 □ F Months Days Hours Jan. 8, 1926 83 Director 220-14-8710 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show die al Examiner must be notified at 1 TYes 2X No Director Airville PA York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7481 Woodbine Road 17302 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Construction permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Howard Beers Ruth (nmn) Pusev 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 Flintlock Drive, Bel Air, Maryland, 21015 Darlene Taylor / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gdn. 3/7/2009 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Kathlee CPC 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jehmonia **Physician** day disease or condition resulting in death) /Medical Due to (or a consequence of): denentin Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed use as the burial-tran and Due to (or as a consequence of) Box 68760, ding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) P.O. I ed by the a 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 9 been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne Teath 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 11 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

615 WEST MACPHAIL ROAD DR. ROBERT DUNCAN 31. Date filed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29c. License number

028136

BEL AIR, MD.

29d. Date signed (Month, Day, Year)

21014

-5000

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F rtificate of I			ene 2009	9 07279		
	Physicia /Medic		Decedent's Name (First, Middle, Lath Cath	,	Healy	Brown	Х	2. Date of Death Month March 6	Day Year	3. Time of Death 8:15 A M		
No State	Examin		4a. Facility Name (If not institution, gi			T	r Location of Death		4c. County of Dea			
			Stella Maris H	Hospice		Timo	nium		Baltimo	ore		
	Funeral Director		214-20-9794	Sex 7. Ag	e (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 2,	9. Bi 20 Ma	rthplace (State or Foreign ountry) aryland		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	Mary I-f sh	to	Maryland Baltimo	re	Timon	i i im				1 ∐Yes 2 🙀 No		
	h the	irec	10e. Street and Number	<i>.</i>	TIMOTI	10f. Zip Code		10	g. Citizen of What C	ountry?		
	th wit	ral	2525 Pot Spring	Road		21093			U.S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evariment outs to maithed any once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Yes If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🔀 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	te, etc.		
8	Phour	ed	15. Decedent's E	Education	16a. Dece	dent's Usual Occup	ation	10	6b. Kind of Business	White //Industry		
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Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname)			
<u>ya</u>	ould I	ည	Joseph	Р.	Healy					ssett		
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship						City or Town, State,			
ē,	1 and Heal tem 2	1	J. Patrick Brown 20a. Method of Disposition	n Son	20b. Place of Dispo cemetery, crea				York, Net 0c. Location - City or	V York 10022 Town, State		
JO L	ages ent of nt: If if		1 ☐ Burial 2 【 Cremation 3 [4 ☐ Donation [5 ☐ Other (Spec		1		1	2000	Torran	Mararal and		
Baltimore,	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice			2. Name and Addres	ss of Facility Ru	ick Towso	Towson n Funeral arvland	Maryland Home, Inc. 21204		
			23a. Part 1. Enter the disease, or cor	nplications that caused	the death. Do not en					Approximate		
The same	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONGEST	CIVE HEART a consequence of):	FAILURE				Interval Between Onset and Death		
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68760,	icate be executed physician and sthe burial-transit	edical		d								
	ertifica ing ph	Med	IF FEMALE:									
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у		23d. Date of de Month	elivery Day Year		
	res that signed b be deta	by Pr	Part II. Other significant conditions	contributing to death be	at not resulting in the u	nderlying cause give	en in Part I.			o the cause of death?		
ord	w requir s been si should I							1 ☐ Yes	2 X No 3 P	robably 4 🗆 Unknown		
Division of Vital Records,	ding Physician: The law in the law in the certificate has buther this certificate has buthereal director, page 2 st	Completed						24a. Was an autopsy performs 1 🗆 Yes 2	prior to	utopsy findings available completion of cause of s 2 □ No		
Ĭ.	siclan certif rector	Be	25. Was case referred to medical examiner?	Hospital:		Other	ar:	h (Check only one)				
o	Phys	2	1 ☐ Yes 2 📉 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Outpatie	III 3 LI DOA	4 LI Nursing Ho	ome 5 Residen 28d. Describe how		ecify) HOSPICE		
<u>o</u>	nding th. :: Afte	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Worl	(? No		injury cocurrod			
Divis	il or Attending Ph after death. I Director: After th d in by the funeral	ertification:	3 Suicide 6 Could not to determined		Iry - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o	examination and/or in	h occurred at the tire	me, date and place, pinion, death occur	, and due to the car red at the time, dat	use(s) and manner a te and place, and du	is stated. e to the cause(s)		
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	TCIOnes ner sta	ited.	29c. Licens	e number	290	d. Date signed (Mon	th, Day, Year)		
	->-0		> ALLAO	ense		RIL	19797		3/1/208	19		
	21		30. Name and and dress of person who	completed cause of d	eath (Item 23a) (Type,	Print)			Jujan	1		
	31		JACKIE JONES, (CRNP 2300	DULANEY VA		TIMONIU	M, MD 210	93			
	Sta		31. Date filed (Month, Day, Year)	32. 1 egiste	r's Signature				·-·-			
	Registr	ar	MAR 1 0 2	009 Leven	~ B. A.	are						

8:15 а.ш.

MARCH 6, 2009

CATHERINE BROWN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 27, 2009 **Physician** February 4:30 AM M Da'Mari Andrew Berry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 2009 infant Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, In Medical Exert. In the De notified as traumatic event, In Medical Exert. 1 ☐ Yes 2√ No Director MD St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20650 41490 Norris Street #20 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 □Yes 2 No Specify <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 12 should be filed w h and Mental Hygies 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aishah Steward Daryl Berry ၉ Department of Health and Important: If item 27 is ma any injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $25500\,$ Point Look Out Leonardtown, MD $20650\,$ 19a. Informant's Name/Relationship (Type. Print) St. Mary's Hospital Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funcial Service Scensee Wade State and Address of Facility and 655 W. Baltimore Street Darector 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Im matur Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably funeral director, page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. To the l within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Mary's Hospital Leonardtown MD 20650 Valinda Nwadike 31. Date filed (Month, Day, Year, Registrar

Berr

Andrew

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		1	For State Registrar	State of Marylar		artment of H <i>rtificate of I</i>		ntal Hygiei 		0128		
			1. Decedent's Name (First, Middle, Las	<i>t)</i>			2	Date of Death		3. Time of Death		
Physi /Med			John Bryant					LOTURY,	RY 27, 2009 855 an			
Funera	nine al	r '	Aa. Facility Name (If not institution, give Makyland Grenera) 5. Social Security Number 6. Security Number 11	al Hospital		Baltin	r Location of Death OCC If Under 24 Hrs. 8 Hours Min. T	ty	ar) Co	hplace (State or Foreign untry) unk		
	91	E	Usual Residence of Decedent					uii 7, 17	JJ Hai			
show		ااد	10a. State 10b. County	10c. Ci	ty, Town or L Baltiı					10d. Inside City Limits 11√2 Yes 2 ☐ No		
he M		6010	10e. Street and Number		Daiti	10f. Zip Code		100	Citizen of What Co			
with t	3	ב	501 W. Franklin	Street		101. Zip 000e	21201	1.09.	USA	and,		
s 1 and 2 should be filed within 72 hours after death with the Maryland s 1 and 2 should be filed within 72 hours after death with the Maryland Itemat and Mental Hygiene. Itematic and Mental Hygiene show other traumatic event, Itematical Examinat must be rediffied at		by Funeral Director	11. Marital Status unk 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Specifi an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Ame Black, White			
72 ho		ered Sted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	ation during most of working d)	unk 16b	Kind of Business/	industry unk		
within jiene.		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired ainter	3)		Residen	tial		
tal Hyg		o n	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name (unk		
should be and Mental marked o		<u>•</u>	Frank Bry		10h Mail	ing Address (Street	Edith Chi			Zin Code)		
alth and 27 is r			19a Informant's Name/Relationship (Terry Sann/niece Maryland General	2	827	Bloomsbu Linden A	and Number or Rural F I ry Avenue Jenue Balti	Baltimo more, MI	re,MD 21:	228		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then eny injury or other traumatic event, tra Ma			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ♣ Other (Specify	Removal from State	Place of Disp	osition (Name of matory or other place	Dat		. Location - City or	Town, State		
permit. Departr Importa eny inju	once.		21. Signature of Funeral Service Licen	Wade, Directo	1		omy Board (655 W. B	altimore	Street		
Physicia /Medica Examine	al er	9r	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consection) Due to (or as a consection)	th. Do not en	iter the mode of dyin	MD 21201 ng, such as cardiac or r	espiratory arrest,	1052	Approximate Interval Between Onset and Death		
icate be executed physician and s the burial-transit		ai Examiner	cause Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):							
		edicai		d								
OI VICAL DECOLUS, T.O. DOX OF Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	1	23d. Date of delivery Month Day Year						
s that		by Pr	Part II. Dthar significant conditions of	23e. Did tobac	. Did tobacco use contribute to the cause of death?							
w requires to been signed should be			Periphera	l vasc	la	r dis	ease	1 Tes	2 No 3 Pr	obably 4 Mnknown		
20 a a c		Completed	Bilatera	e leg c	amp	utati		24a. Was an autopsy performed	death?	utopsy findings available completion of cause of		
VICATIONAL INCIDENTIAL INCIDENTIAL PROPERTY PROP		Be	25. Was case referred to medical examiner?	Hospital:		ont 3D DOA Oth	26. Place of Death (
on or ding Phys h. After this funeral di		٠. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time	ALL DON	4 Nursing Home	d. Describe how i	e 6 □Other (Spe njury occurred	city)		
nding ath. r: Afte		atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		rk? Yes 2 □ No					
JIVISION or Attending efter death. Director: Afte		Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, s	treet, factory, office	28	f. Location (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,		
To the Hospital or Attending Physician: The within 24 hours elier death. To the Funeral Director: After this certificate h completely filled in by the funeral director, Age		dical	(Check only 2 Medical Exar	lysicien: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occurred	at the time, date	and place, and due	to the cause(s)		
To the within To the comp		Me	30. Name and address of person who sufficiently and 31. Date filed (Month, Day, Year)	M. D		29c. Licens	0/7202	29d.	Date signed (Mont	h, Day, Year)		
			30. Name and address of person who	completed cause of death (Ite	pm 23a) (Type	Print Ane. 1	Partimo/	md.	2/222			
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrar's 9 gr	nature	2.1	20011111012	/				
Reg		ar	MAR 1 0 2009	Denne B.	Mark							

DHMH 17 Rev 1/2001

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	1. Decedent's Name (First, Middle, Last)
Physician /Medical	MARGARET
Examiner	4a. Facility Name (If not institution, give s

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name	e (First, Middle, Las	st)				-		2. Date of Death 3. Time of Death					
an	MAR	GARET		BA	SSAN		MA'R	CH '	Day 8	2009	5:10	MA C		
cal 1er	4a. Facility Name (/	If not institution, give	e street and number)			4b. City, Town, o	r Location of D		4c. County of Death					
	7908 W	INTERSET	AVENUE			BALT	IMORE		BALTIMORE					
	5. Social Security N	lumber 6. S	ex 7.Ag	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of (Month,	Birth	ar)	9. Birthpl	ace (State	or Foreign	
	217-18	- 0213 1	Monuis Days	Tiouis	Min. 09/29	7192	20	Count	HUN	GARY				
	Usual Residence of			10.05.7							140			
-	10a. State 10b. County 10c. City,					cation					10	d. Inside C	2 No	
Scto	MD BALTIMORE					BALTIMORE							2 <u>M</u> 1N0	
ă	10e. Street and Nur					10f. Zip Code	208		10g.		What Count	ry?		
2	7908 WI	NTERSET A					_	SA						
nue	11. Marital Status		Ever in U.S.	In U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri					ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.					
×	1 ☐ Never Marri 3 🕅 Widowed	ied 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No	-	1 □Yes 2 🛣 No	Specify:			Specify: WHITE				
Completed by Funeral Director	3 IA Wildowed	15. Decedent's Ed	Year or Dates:	16:	n Decer	dent's Usual Occup	ation		16h	16b. Kind of Business/Industry				
Set		cify only highest gra	de completed)		(Give	kind of work done DO NOT use retire	during most of	working		. Killa of Be	23111E337111Q1	25ti y		
E	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)		PARALE	•				LAW			
Be	17. Father's Name	(First, Middle, Last)					18. Mother's	Name (First, Midd	(First, Middle, Maiden Surname			ne)		
F B	MOSHE		HOLL	ANDER			SA	ARAH	H (GROSS		
1		ame/Relationship (b. Mailir	ng Address (Street			Route Number, City or Town, State, Zip Code)					
	LAURIE	BASSAN /	DAUGHTER		11	.408 MONT	ICELLO	AVE., SI	LVE	R SPR	ING.	MD 20	0902	
-	20a. Method of Dis			20b. Place	of Dispo	sition (Name of	i	Date			City or Tov			
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 BETH TFILOH CONG. 03/09/2008 BALTIMORE, MD													
	- Estate (epstay)									ISON & BROS., INC.				
	8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208													
	23a. Part 1. Enter t	the disease, or com	plications that cause	the death. Do								Approximat	te	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Parkinson's disease.												Interval Bet Onset and		
	disease or condition resulting in death) a. Due to (or as a consequence of):													
Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):													
amj	Cause (Disease or injury that initiated events c													
Ä	resulting in death)	Last	Due to (or as	a consequence	of):									
Physician/Medical Examiner		d												
Mec	IF FEMALE:													
ian/	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 Fetal deat	th 3 🗆	Ectopic pregnanc		23d. Date of de Month				Year		
Sic	1 ☐ Yes 27 9 ☐ Unknown	No	4 ∐ Pregnant a 9 ☐ Unknown	at time of death	5 L	Other (specify) _			-			,		
			ontributing to death b	ut not resulting	in the ur	nderlying cause giv	ven in Part I	23e Di	d tobacc	n use cont	ribute to the	cause of o	death?	
by	Tarrai Gillor Gigini	nount contains to	oning to dod!!! b	at not resulting		idenying educe giv	on in raiti.			2. X No				
24a. Was an autopsy prior to comple death? 25. Was case referred to medical examiner? 25. Was case referred to medical examiner?									☐ Probably 4 ☐ Unknown					
								prior to com	topsy findings available completion of cause of					
								2 □ No						
P.	1 ☐ Yes 2 € 27. Manner of Deat		1 ☐ Inpati		Outpatier Time of	IL 3 LL DUA	4 🗀 Nursir	ng Home 5/R)		
io	1 Natural	5 Pending	(Month, Da	y, Year)	Injury	Wor		28d. Describ	e now in	ijury occurr	rea			
2 Accident investigation M 1 Yes 2 No 3 Suicide 4 Homicide Could not be determined building, etc. (Specify) 28f. Location City or								/Stroot	and Numb	or or Puml	Pourto Nun	nhor		
erti	4 Homicide	determined	building, et	c. (Specify)	arm, our	oct, lactory, office		City or	own, St	ate)	er or riurar	riodie ridii	ilber,	
1 Yes 2 No								anner as st	eted hate					
								and due to	the cause(s	s)				
Me	29b. Signature and	title of certifier				29c. Licens	e number		29d.	Date signe	d (Month, D	ay, Year)		
	\(\lambda\)	1/	100			100	44296		March 8,20			009		
	30. Name and addr	ress of person who	completed cause of o	death (Item 23a)) (Type.	Print\								
	705 Digit	tal Drive	, Suite G	- Lint	hice	im, Mi	210	go MARIA	NNE	RUTIO	GLIAN	O, MD		
ate	31. Date filed (Mon	nth, Day, Year)	Suite G	ar's Signatu	6	a del								
rar	1	MAR 1 0 20	NY Canon	N p.	19									

Regist DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Age (In yrs. last birthday) (State or Foreign **Funeral** Days Hours 1□M 2**V**F Months Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 1 ☐ Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces 1
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS J. COAD ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is rr any Injury or other traum once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 20c. Location - City r Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 8800 HAHORD FOAD PARKVILE, WID 21237 ENAILS FUNERAL (HAFELT CREMATION SERVICES-PARKVILLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOD HAND OF EVANS FUNESCE (HAFELY CREMATIVE Shock, or learn failure). List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronoru VVS /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 Unknown Completed Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: ၣ 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes death. 2 □ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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	-	For State Registrar				,		rtificat					Reg. No.	005	U	7284
Physicia		1. Decedent's Nam		Last)	00	(_6 N C	UF	R			2. Date of De Month	Day		r_	Time of Death
/Medic	al	4a, Facility Name (L (PP		_0// 0			r Location	of Death	03	40.0	County of De	-	250 M
Examin	er	Anne Ar					er	1		olis	OI Death			ne Ar	_	e1
Funeral		5. Social Security N 169-20-52		6. Sex			last birthday		r 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Pa Aug 24			irthplace	(State or Foreign
Director				1□M :	2 F	82	Yrs.	Wichters	Days	110010		Aug 24	1926	Per	nnsýl	lvania
land ow		Usual Residence o 10a. State	10b. County			10c. Cit	y, Town or L	ocation							10d. li	nside City Limits
Mary a-f sh	by Funeral Director	NY	Madis	on		(Cazen	ovia							1	□Yes 2X No
I and 2 should be filed within 72 hours after death with the Maryland of Health and Menalth Hygiene. If Health and Menalth Hygiene. If file and the marked other than "natural", or Items 23a or 28a-f show other traumatic avant, Inc. Medical Exam.		10e. Street and Nu 4986 R		oad				10f. Zip	1303	35			10g. Citiz	ven of What USA		
ems 2	iner	11. Marital Status			as Decedent		.S. 13.	Was Dece If Yes, spe	dent of H	lispanic Or an, Mexica	igin? (Sp n, Pu <i>e</i> rto	ecify Yes or No Rican, etc.))- 1	4. Race - Ai Black, W		ndian,
s afte	y Fu	1 Never Marr 3 Widowed	ied 2 Marri	lf.	☐ Yes 2 Yes, Give ear or Dates:	No		1 ☐ Yes		Specify.			1	Specify: W	hite	<u></u>
2 hour			15. Decedent	's Education	ation 16a Decer			edent's Usu	edent's Usual Occupation					nd of Busine		
thin 72	Completed	(Special Elementary/Second	cify only highes andary (0-12)		ollege (1-4or	(Give kind of work done during most of work life. DO NOT use retired)					ang					
led will lygien her th		47. 5-1b-1- Name	/Cima Middle /		Homemaker				r	19 Moth	or's Nam	e (First, Middle	Own Home			
d be fi	Be	17. Father's Name Samuel	Lip								nela		arke	Sumame)		
an y and a filed within 2 should be filed within and Mental Hygiene. Is marked other than aumatic avant, the Mental avant avan	ပ	19a. Informant's N			rint)		19b. Mai	ling Addres	s (Street			al Route Numb		Town, State	, Zip Cod	(e)
tand 2 tand 2 Health a tam 27 is		${\tt Donald}$	Conov	er -	son						oad,	Annapo:	lis,	MD 2	L403	
es 1a of He of He of tam r othe		20a. Method of Dis	position Cremation	3 □Remov	val from State	20b. F	Place of Disponentery, cre	osition (Na ematory or	me of other plac	ce)		Date		cation - City		
Pages tment of tant: If its		° 4 □ Donation	5 ☐ Other (Sp	ecify)		Met					_	9/2009		timore		
partification of permit. Pages 1 am Department of Heali Important: If itam 2 any injury or other once.		21. Signature of F	H	uli	lillian			299 F	'rede	rick	Road	of Mary l, Balti	imore		2122	28
		23a. Part1. Enter shock, or he	th e d isease, or art failure. List	complicatio only one ca	ns that cause use on each l	d the deat ine.	h. Do not er	nter the mo	de of dyin	ng, such as	cardiac	or respiratory a	rrest,		Inte	proximate erval Between set and Death
Physician		Immediate Cause disease or conditi- resulting in death)	on	a	2	eps	in								3	0
/Medical Examiner		rooming in accord			Due to (or as	a konseq	uence of):	ANG	NE	TAS	7	mets			6	01)
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	onditions, mmediate Due to (or a			to (or as a consequence of):										
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te be executed ysician and le burial-transit	I Ex	resulting in death)	Due to (or as	to (or as a consequence of):												
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The COLOS, T.O. BOX 00/ The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	ician/Medi	IF FEMALE:	nt pregnant		yes, outcome								2	23d. Date of	delivery	
death death e atte	sicia	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown						□Ectopic p □ Other (s				Monti			n Day Year	
at the defective etacher	Physi	9 Unknow		-		but not roa	ulting in the	undorhina	201100 001	on in Part		23a Did	hid tobacco use contribute to the cause of death?			
signer d be d	by	Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I.								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
he law requires in he law requires in has been signage 2 should be	ietec		Nov-ac			1	0000	-	0			24a. Was	an	24b. Were	autopsy f	findings available
he la he has age 2	Completed											auto		prior death	o comple	tion of cause of
	Be C	25. Was case refe	erred to medical							26. Plac	e of Dea	th (Check only				
Physici Physici rhis ce	To	O 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify,								pecify)						
Ing P	ion;	27. Manner of Dea	5 Pendin	g	Ba. Date of Inj (Month, D	ury ay Year)	28b. Time Injury		28c. Injur Wor	ryaat rk? !Yes 2.⊑	1No	28d. Describe	how injury	y occurred		
DIVISION Of VILA If or Attanding Physician: after death. Director: After this certification by the funeral director.	ficat	2 Accident 3 Suicide	investig 6 Could r determ	not be	Be. Place of Ir	njury - At h	ome, farm, s				21.10	28f. Location (Street and Number or Rural Route Number,				ute Number,
al or /	Certification:	4 ☐ Homicide	dotom		building, e	etc. (Speci	fy)					City or 10	wn, State))		
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai (29a. Certifier (Check only one)	Certifyin	Evaminer:	On the basis	of examina	ation and/or	nyectication	n in my o	ninion de	ath occur	and due to the red at the time,	date and	place and r	lue to the	cause(s)
/ Det within the company of the comp	Me	286. Signature an	d title of dertifier	1		A	,	29	c. Licens	se number	(2.0		29d. Date	e signed (M	onth, Day,	Year)
A		710	4	/ -	76 Yr	$\sqrt{1}$	qui		0	VI	158		M	arch	08	2004
		30. Name and add	dress of person	who comple	eted cause of	death (Iter	m 23a) (Type	Print)	70,	EFE	NSE	HaH	WAY	ANN	A Pol	43 MO44
Sta Regist		31. Date filed (Mo	nth, Day, Year)	2009	2. Regis	trar's Sign	ure for	wed .				-				Year) ,2009 Ly Mory
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mend #15 Per TNF G916 6/24/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Yea **Physician** MARCH 2009 02:31AM emor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. gept. 1 M 2 □ F Rennsylvania 218-48-0114 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director TIMOR 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 2121 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. items 14. Race -11. Marital Status 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ Yo Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than linister Kelia 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental + $^{\smallfrown}\Omega$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 nkne Baltimore MD 21215 Health blores item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Dațe 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State idae Mikesville 4 ☐ Denation 5 ☐ Other (Specify) reral 21. Signature of Funeral Service Licensee 22. Name a Address of Facility Home Bultimore, MD 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MONTHS ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O, Box 68760 pe Physician/Medical The law requires that the death certificate signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown been si should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s this certificate 2 1 ☐ Yes 1 ☐ Yes ol or Attending Physician: after death. director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural
2 Accident Injury 5 Pending investigation 1 □Yes 2 □ No neral Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 DØØ57593 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND DRIVE 31. Date filed (Month, Day, Year) FR State MAR 1 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 20^{Year} Josephine R. Compton 1919 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ann Arundel Medical Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Dec. 29, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 212-26-4377 1 □ M 2 2 F 79 Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits MD Baltimore Director Middle River 1 ☐ Yes 2 TXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 Fox Glove Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐Yes 2 ∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other that any lnjury or other traumatic event, It and once. Rite - Aid 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasquale Cascio Catherine Imbruguillo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart Sullivan /nephew 1649 Millersville Road Millersville MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Redeemer 3/9/09 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Homeof Essex 21221 alis 23a. Part 1. Enter the disease, Succomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONARY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy 4 ☐ Pregnant at time of death Month Dav Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 : autopsy certificate perform 2 100 1 □ Yes 2 40 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 N 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

within 2.

29c, License number

00

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 200^{Year}_{9} Month Day **Physician** 10:45a M Clark Sr. Charles Edward March 4 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days 1 3 M 2 □ F 76 27 1932 233-48-7890 Nov **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No Taneytown Carroll Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21787 5120 Haines Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Korea 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No ծ 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Atlantic & Pacific permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any injury or other transmetts. Elementary/Secondary (0-12) College (1-4or 5+) baker Tea Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Mollie Mae Trail Garland Boyd Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 510 Lacosta Circle, Apt 204, Westminster, MD 21158 John A. Clark (son) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 3-7-09 Svkesville, MD Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Haight of enbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMOUNLY BSTRUCTIVE HRONIC 3 GEAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as 1 IF FEMALE for use If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No certificate 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dore Hors Hospital: 1∐ Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03/05/2009 (yelus D31660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONER AVENUE Chesminico wanter 1 Howes 31. Date filed (Month, Day, Year) State MAR 1 0 2009 Registrar

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			State of Maryland / D 1 - State Registrar	epartment of H Certificate of L			giene200	9 07288		
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death		
	Physicia /Medic		Maureen Phyllis Carlson			Month March		10:00pm ^M		
	Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death 4c. County of Death					
			7200 Third Avenue U-402 5. Social Security Number 6. Sex 7. Age (In yrs. last birth		kesville	8. Date of Birth	Carrol1			
	Funeral Director		046 04 1001	rs. Months Days	Hours Min.	Feb II,	1931 °	Birthplace (State or Foreign Country)		
			Usual Residence of Decedent							
	72 hours after death with the Maryland ratural", or items 23a or 28a-f show dical Examiner must be notified at	tor	10a. State 10b. County 10c. City, Town Carroll	Sykesv	ille			10d. Inside City Limits 1 □ Yes 2 No		
	ith the or 28a	Funeral Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Country?			
	s 23a	eral	7200 Third Avenue U-402	2178		ocify Voc or No	USA	American Indian,		
_	ter de item	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	13. Was Decedent of Hi If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.		
9500-612	urs af	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □ Yes 2√□ No	Specify:		Specify: White			
ဂ ဂ	72 hours "natural"; dical Exa	eted	15. Decedent's Education 16a. ((Specify only highest grade completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of work	ing I	16b. Kind of Busin	ness/Industry		
7	be filed within 72 hortal Hygiene. d other than "natuevent, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	1)		tio			
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Mary	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic			Mailing Address (Street a			-			
	l and lealth im 27		, , ,	.52 Brangles		riottsv Date	ille, MD			
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	permit. Pages Department of Important: if it any Injury or o		4□Donation 5 ♥Other (Specify)Entombment Boca R 21. Signature of Funeral Service Licensee				Boca Rate	on, FL		
ñ	Dep Imp any		Blim C. Arunt MODIGY	HAIGHT FUN PO Box 195	ERAL HUMB Svkesvil	E & CHAP Lle, MD	'EL, PA 21784			
F	-		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	rest,	Approximate Interval Between					
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מֿ כ	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 1 □ Hels over the first time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	<i>'</i>		Month Day Year			
<u>.</u>	hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did to	obacco use contribute to the cause of death?			
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ecord	law req as beer 2 shou	olete	Conelmoronala disecuse			24a. Was a	re autopsy findings available			
Ï	e <u>ii</u> e	Completed	conditionascular diseas	€.		autop perfor 1⊟ Yes	rmed? dea	prior to completion of cause of death? o 1 □ Yes 2 □ No		
VItal	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Deat					
0	Physician: this certific ral director,	7	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of Injury 28b. Ti	patient 3 DOA Othe	4 LI Nursing Ho		lence 6 Other			
	ding Phys th. : After this funeral dir	tion			8c. Injury at Work? 1 Yes 2 No					
JIVISION	l or Attendafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	Street and Number (vn, State)	or Rural Route Number,					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the tin l/or investigation, in my o	me, date and place, ppinion, death occur	and due to the dred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)		
	To the I within 2.	Me	29b. Signature and title of certifier	29c. License			29d. Date signed (I	Month, Day, Year)		
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4				Type, Print) Coty Rd	Elderst	nus M	D 217	84		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 9

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Dav Year 2000 Robert J. Cramblitt 21:44 PM MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay,)
Aug. 13, N/A SINAT HOSPITAL OF BALTIMORE 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 72 212-34-4411 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show notified at MD N/A Baltimore 1 Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be 21215 2525 West Belvedere Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Loader Food or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Miller Harry Cramblitt and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Thornberry Drive, Edgewood, MD 21040 19a. Informant's Name/Relationship (Type. Print) Nancy Knott - Daughter nt of Health a Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 3-6-2009 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facili Ambrose Funeral Home, Inc. Since ture of Funeral Service LP 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Long Physician Septicemia /Medical Due to (or as a consequence of): Examiner 1sche mia Bowel Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): Examiner burial-tran The law requires that the death certificate be execu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peripheral variular disease 1 Probably 4 Unknown Completed Bipolar disorder 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an nerforme DEpression 2. No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS RES-000 MARCH 3 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PALTAM NEUPANE MBBS, SINAL MOSPITAL OF BRITIMORE

31. Date filed (Month, Day, Year)

32. Jegisnar's Signature 31. Date filed (Month, Day, Year) MAR 1 0 2009 Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	aryland		artment of F rtificate of	Health and M Death	lental Hy	/giene Reg. No.	09	07290
			1. Decedent's Name (First, Middle, Las	t)					2. Date of D		Year 3	. Time of Death
	Physicia			James	Earl	Cani	non			RCH 5,	2009	11:34AM
	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph		Cent	er	4b. City, Town, o	r Location of Death	วท	4c. Count	y of Death Baltí	more
	Funeral Director		5. Social Security Number 6. S 219-62-6790 X	ex 7. Age	6 (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 3-4-1	irth Pay, Year) 957	9. Birthplace Country)	S.C.
7	2		Usual Residence of Decedent								1401	
-	show	_	10a. State 10b. County		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Town or Lo						Inside City Limits ↑ ↑ Yes 2 No
	8a-f	Director		/A	Bal	timo						21
1	23a or 2	ral Dir	10e. Street and Number 1418 Cedarcrof	t Road			10f. Zip Code 212	39			What Country?	
	ems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or N Rican, etc.)		ice - American I ack, White, etc.	Indian,
9036	be fled within 72 hours after death with the maryland the Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Eventiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X】 Divorced	1 ∐Yes 2 X N If Yes, Give Year or Dates:	10		1⊡Yes x⊡x No	Specify:		Speci	fy: Blac	:k
2-6	/2 ng 'natu	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual Occup kind of work done	during most of working	ng	16b. Kind of E	Business/Indust	ry
2	han he.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. i	DO NOT use retired Disabl	•		Dis	abled	
7	Hygie Hygie Shert		10th grade 17. Father's Name (First, Middle, Last)	I.	I/A		DIDUDI	18. Mother's Name	(First Middle			
anc	e d d	Be							,		,	
2	should and Mer s marke umatic	2	Herman Cannon 19a. Informant's Name/Relationship (Type Print)	I	19b Mailir	ng Address (Street	and Number or Rura		Living ber. City or Town		de)
<u> </u>	# 1 = a		Doris Cannon-Ma		a + a x			n Drive		o, MD		40)
. ئو	ges 1 and 2 should tt of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	ickino=5]			sition (Name of natory or other place		ate		- City or Town,	State
	i ii e a		1√ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Carlo Maria	Mor	elan	d Memor	ial 3-13	-2009	Parkv	ille,	MD
Ball	permit. Departn Imports any inju		21. Signature of Fundal Service Live	1100		1	2. Name and Address 1101 E.	ess of Facility Ma North A		ast F/ Balt		21202
			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only	plications that caused one cause on each lir	the death. ne.	Do not ent	er the mode of dying	ng, such as cardiac	or respiratory	arrest,	Int	proximate erval Between
P	hysician		Immediate Cause (Final disease or condition	. SEPSI	3						Or	nset and Death
	/Medical		resulting in death)	Due to (or as								
	xaminer		Sequentially list conditions.	b			SISTANT	STAPHYL	_0C0C0	CUS		
./	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
X	and and I-tran	хаг	that initiated events resulting in death) Last	c. AUREI Due to (or as			EMIA		-			
8760,	sician and burial-transit			AORTI	•	-	NDOCARD	TTIS				
687	physicate the true to	dical		d		on V teams down	a Tour toor tort to the	1 10 100				
O. Box (res mat the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			ate of delivery Month Da	y Year
۵.	mar r ed by detar		Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cor	ntribute to the c	ause of death?
ds,	urres sign d be	d by	ACUTE RENAL	PATLURE					1 🗆	Yes 2 No	3 ☐ Probabl	y 4 🗆 Unknown
Ö	w require s been signal	ete	HYPERKALEMIA						24a. Wa	s an 24h	Were autonsy	findings available
I Re	cate has	Completed	HIPERRALEMIA						auto	opsy formed?	prior to compledeath?	etion of cause of
Įį.	cran sertifi sctor,	Be	25. Was case referred to medical examiner?	Hospital:			Tout	26. Place of Death	(Check only	one)		
5	this of	은	1 ☐ Yes 24 No	1 Inpatie			IL 3 LI DOA			sidence 6 🗆 O		
u .	After After funer	i.i.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	Wor	rk?]Yes 2 \Bo	28a. Describe	how injury occu	irrea	
Division of Vital Record	to the hospital of Attending Prystolan; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: To	Accident investigation Accident investigation Could not be determined		ury - At hon c. <i>(Specify)</i>	ne, farm, str	reet, factory, office			(Street and Num own, State)	nber or Rural Ro	oute Number,
	Hospital 24 hours Funeral stely filled	Medical Co	29a. Certifier (Check only one) Medical Exar	ysician: To the best niner: On the basis of and manner st	f examination	ledge, deat on and/or ir	h occurred at the to	ime, date and place, opinion, death occur	and due to the	e cause(s) and re, date and place	manner as state e, and due to the	ed. e cause(s)
:	vithin To the comple	Mec	29b. Signature and title of certifier A	- P	h		29c. Licens	se number		29d. Date sign	ed (Month, Day	r, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D24034 State Registrar DHMH 17 Rev 1/2001

09-01869 Ron Lee Calhoun	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	100
	1- For State Certificate of Death Reg. No. 2009	0729
Physician/ Medical Examiner	Ron Lee Calhoun Month Day Year 23	ne of Death 13 hrs
We di	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace	(State or Foreign
Director	213-98-7516 1X _{M 2} F 27 Yrs. Months Days Hours Min. 6-21-1981 Country	MD
And Andrews	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ir	nside City Limits
Maryland 28a-f show d at once. ector	MD N/A Baltimore 10g. Citizen of What Country?	Yes 2 No
after death with the Maryland ral', or items 23a or 28a-f sho inc must be notified at once. by Funeral Director	1311 Silverthorne Road 21239 U S A	
or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Ind White, etc.	lian, Black,
fir. dea		ck
136 Lin 72 hours aft. c. than "natural" edical Examine	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry during most of working life. DO NOT use retired)	
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed I	12th grade 1 year Crew Chief	
2 1215-003 out be filed within the filed within it is marked other the ice event, the Media To Be Comp		· · · · · · · · · · · · · · · · · · ·
MD 2 '215-0036 1 shout be filed within 7 th and Mental Hygiene. 127 is marked other than umadic event, the Nedical To 'Be Comple	James L. Calhoun Pearlie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	ode)
2 2 5 5	Pearlie Davis-Mother 1311 Silverthorne Road Balto, MD 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, S	
	1 XBurial 2 Cremation 3 Removal from State crematory or other place) Arbutus Memorial 3-11-2009 Arbutus MF	
Baltir permit. P Departme Importar injury or	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	21202
/Medical Examiner	Immediate Cause (Final disease a. Head and Neck Injuries	ween Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,	
niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Comparishments leating Comparishments leati	
executed an and al-transit ical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	10
e executed cian and rial - transit dical Ex	UNPENDED AMENDED	
D. Box 68760, the death certificate be to the attending physicia ched for use as the buria ched for use as the buria Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
OX 60 sath cert attendir for use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	real
cords, P.O. Box 68760, law requires that the death certificate be ex has been signed by the attending physician 2 should be detached for use as the burial upleted by Physician/Medic		se of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P		
of Vital Records, ing Physician: The law required Physician: The law required after this certificate has been signeral director, page 2 should be not. To Be Completed	24a, Was an 24b, Were autopsy fir autopsy prior to completing performed?	
al Re an: The ertificat tor, pag	25. Was case referred to medical 26.Place of Death (Check only one)	2 No
f Vita Physicia er this ce ral direc	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA Vire 4 Nursing Home 5 Residence 6 Other:	
on o ending sath. or: Aft the fune	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending Ar 5, 2009 28b. Time of Injury 2234 hrs 28c. Injury at Work? 1 Yes 2 No Driver auto auto collision	
Division of spiral or Attending I hours after death. Inneral Director: After y filled in by the funer Certification:	Accident Investigation Suicide 6 Could not be determined a Suicide 8 Could not be desired a Suicide 8 Could not be determined a Suicide 8 Could not be determined 8 Could	
C Till Port		
To the He within 24 within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	``
¥ ≥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day O.C.M.E. March 6, 2009	', Year)
	30. Name and address of person who completed cause of death (Item 23a)	
State	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar		

09-01869

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Year **Physician** 2:05 AM 3/0 /Medical of Death Facility Name (If not institution, give street and number) **Examiner** ISTOUR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/30/1946 Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 X M 2 □ F 152-36-9113 62 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evant in rount to moth North East MD 1 Xes 2 No Director Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21901 USA 520 South Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 BYes 2 □ National If Yes, Give Year or Dates: Guard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: \$ 3 Widowed 4 XX ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hazmat Control Hazmat. 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be dorothy Kiesel Kelsay Benjamin Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trauonce. 116 Saint James Court, Elkton, MD 21921 Katina Knox / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/9/2009 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Name and Address of Facility
Maryland Cremation Services
Po Box 1413, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, non each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical up to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a someway reviol Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the pest 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Paft)!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ☐ No 2 🛛 No 1 🗆 Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOPPIR 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached certificate director, this funeral After To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

28a-f show

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death with

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie

29a. Certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed of death (Item 23a) (Type, Print)

Date filed (Month. Day, Year)

MAR 1 0 2009

32. Pegistrar's Signature

Registrar

Medical

State

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Cutler 2009 5:30 P Dorothy Jean March /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1009 Misty Lynn Circle Baltimore Timonium 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 💢 F 70 Nov 10, 1938 Director 251-58-1234 North Carolina Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2XX No Directo Timonium Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 **USA** 1009 Misty Lynn Circle, apt. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 03 n/a <u>Hostess</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacobs ပ Clark B.J. Marv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Randy D. Cutler/Husband 23 Sunnyview Drive, Phoenix, Maryland other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/5/09 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Fu 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 7UR nronic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Completed by Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No certificate has birector, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1∐Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.

leral Director: /
filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier heer Eldwords D0015808 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

William E. Randall R., M.D. William 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James Ward Colley NEWZLI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Glen Burnie <u>Anne</u> <u>Arundel</u> | House | Hous Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 206-14-2357 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6526 Clear Drop Court Unit 104 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 27☐No Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer/Pressman Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Flye Colley Edra Wall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jerry Colley /Son 6213 Chestnut Oak Lane Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) March Date 20c. Location - City or Town, State 20a. Method of Disposition 12 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Holy Redeemer Cem. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MO135 anur 23a. Part 1. Sotar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumo Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mychael Expriner intel by netified 31 once.

Baltimore, Maryland 21215-0036

COLLEY, JAMES

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical δ Completed Be Certification: To

		7
		24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	(Check only one) form one 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Dean Natural 5 Pending 2 Accident investigation	(<i>Month, Day, Year</i>) Injury Work? on M 1 ☐Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical 29b. Signature and title of certifier Name and add

29a. Certifier (Check only one) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 1335 ames March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Springfield 8. Date of Birth (Month, Day, Year) **Funeral** Hours 295-22-5344 78 Yrs. Director September 9.1930 Usual Residence of Decedent the Maryland or 28a-f show notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Cooksville Howard Md. 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ Pages 1 and 2 should be filed within 72 hours after death with ms 23a or must be n USA 21723 1766 Oakdale Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 □ No If Yes, Give Year or Dates: Army items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 9 1 ☐ Yes 2X No Specify: þ Specify 3 Widowed 4 Divorced "natural" Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l other than " vent, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Military Intelligence 12 U.S.Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic eve Nellie Gray James H. Compston ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra 1766 Oakdale Drive Cooksville, Md. 21723 Spouse Patricia A. Compston 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3-10-2009 Baltimore City, Md. Bayview 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arr ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 - Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown signed by Id be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No npatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury after death. Director: After 1 Yes 2 🗌 No completely filled in by the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier

41

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ND

■ Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:33 A M JOHN BARRY CENTINEO MARCH 7 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1308 Gates Head Dr. 21014 8. Date of Birth (Month, Day, Y Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours Min. Months 1 □XM 2 □ F Maryland 1942 Director 66 219-40-0968 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Modical Exercit was the matter. 1 ☐ Yes 2√ No Director Harford Bel Air Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21014 1308 Gates Head Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) State Government <u>Director</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Marie Barry James Nicholas Centineo I ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1308 Gates Head Drive, Bel Air, Maryland, 21014 Mary C. Centineo / Wife permit. Pages 1 and Department of Heat Important: If item 2 any injury or other Odce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdn. 3/11/2009 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Whin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 1 ☐ Yes_ Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending abundance of the Funeral Director. Division of Vital Records, P.O, Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i To the I within 2

Baltimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) her in Schendel MD - 9114 Philadelphia PD, Suite 300 BALTO MD 21237 37 Registrar's Signature

- Physician

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month DeLacy Lynn Cook 2009 7:00 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**反**M 2□ F 85 557-26-5307 March 23 1923 California Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 103 Shetland Hills Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marine Engineer Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Bennett Cook Gravce White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Shetland Hills Dr., Lutherville, MD 21093 Marjorie Cook / Wife 20a. Method of Disposition 20b; Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 03-10-2009 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign ture Fineral Service Licensee 1050 York Rd., Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural

Physician

Examiner

Director

Funeral

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Completed

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Physician/Medical

Completed

Be

2

Certification:

Medical

Funeral

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatte.

Physician

/Medical

Examiner

burial-transi and

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for

attending physician

signed by

has

After this certificate

death.

the Hospital

within 24 hours after death

To the Funeral Director:
completely filled in by the f filled in by the

certificate be executed

Box 68760

P.O.

Division or Vital Records,

/Medical

2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gosne Mark Gosy 31. Date filed (Month, Day,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Day Year **Physician** 2009 09, 12:55 Cox Edith Marie March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Director March 20,1925 Pennsylvania 219-10-7199 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ∐Yes 2 X No Director Maryland Baltimore Lutherville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1703 Division Avenue 21093 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phoebe Leona Pierce ၉ Henry Clinton Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2202 Lloyd Street <u>Bellevue, Nebraska</u> 68005 Linda C. Ethridge Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Removal from State Department of Important: If It any injury or o Donation 5 Other (Specify) Clynmalira Cemetery 3-13-2009 Phoenix Maryland 21. Signates of Contral 22. Name and Address of Facility vide Licensee Ruck Towson Funeral Home, Inc. and <u> 1050 York Road</u> Towson, Maryland 21204 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician undentun disease or condition resulting in death) /Medical Due to (or as a cons quence of): inknown summerold Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Meumoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural

Examiner The law requires that the death certificate be executed use as the burial-tran Box 68760. Division or Vital Records, P.O. been signed by the should be detached cate has t After this certificate funeral director, pag To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

item 27 l

Pages 1

2 Accident

5 Pending investigation

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00060 248 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

North Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulfmores Street

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 1 0 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Februar **Physician** 2:47 PM Kenneth Michael Carson Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 21, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F 55 1953 Connecticut 214-58-2780 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be indiffed at 1 ∐Yes 2√∑ No Hagerstown Director MD Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 USA 750 Dual Hgwy Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 71-72 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: white Completed by 3 ☐ Widowed 4 🂢 Divorced unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Sexton Kenneth Michael Carson Sr ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trauonce. 20715 12412 Skylark Lane Bowie, MD Jimmy Carson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐Other (Specify) 21. Signature A Luneral Service Sicensee State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 111 **Physician** nown /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ 2 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral L

completely filled 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗍 📗 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check one) 29b. Signa use and title 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 07300 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** Рм Thomas Garrett Clagett March 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 24 Hrs. Holy Cross Hospital

5. Social Security Number 6. Sex Montgomery 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear Months Days Hours 1 X M 2 □ F 51 218-54-9487 August 8, 1957 Director Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Indoortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is mades Experient out to a page. 1 □Yes 2X No Director Maryland Montgomery North Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 12510 Seurat Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) New Home Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Barron Clagett Margaret Higgins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marian Mae Clagett/Spouse 12510 Seurat Lane, North Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition march 10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Lig Robert A. Pumphrey Funeral Home/Rockville, Inc. M01530 300 W. Montgomery Avenue, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician week Sepsis /Medical Due to (or as a consequence of): Examiner Peritonitis 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Diverticulitis burial-tra Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Cirrhosis with Liver Failure 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 1 🗆 Yes 2X No 1 ☐ Yes certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 📉 Natural n 24 hours after death.

le Funeral Director; Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division of Vital Records, P.O. Box 68760, within 2.

> State Registrar

31. Date filed (Month, Day, Year) MAR 1 0 2009

29b. Signature and title of certifier

Lawrence Starin M.d., 3921 Ferrara Drive, Wheaton, Maryland 20906 Registrar's Signatur

in

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D38478

29d. Date signed (Month, Day, Year)

March 7, 2009

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2009 **Physician** Mary Louise Crabill March 6, 9:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth June 2, 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🔼 F 88 Missouri 497-16-6529 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "na Modes" Even "na to ust be not the day 1 ☐ Yes 2X No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 United States 200 Brewster Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 X Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Scientific Editor Journal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Sivers Gurtrude Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Cathy Palmer/ Daughter 4402 Noah Court, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 9, 2009 Bethesda, Maryland Crematorium, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature Juneral Service M0/530 Rockville, Inc. 1300 Vesto Montgomery Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypercap**n**ea /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Ent. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Congestive Heart Failure burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical Coronary Heart Disease the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. ed by the a 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation autopsy perform certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending n 24 hours after death.

le Funeral Director: Aftetely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Winifred Mui-Lin Lee, 1500 Forest Glen Road, Silver Spring, Maryland 20910

D0067901

				For State Registrar	State of Maryla	_	rtment of F tificate of			ien@ () () S ag. No.	07302
_		Physici /Medic		1. Decedent's Name (First, Middle, Las	Josephine	Dar	gan		2. Date of Death	Day Lot	3. Time of Death 29 11: 50 P M
	7	Examir		4a. Facility Name (If not institution, give $Siuoi$ blospitor)	01 00 112	ione,	4b. City, Town, o	In Ole C	idy	4c. County of D	'A
,	E	Funeral Director		24) IT 02/3	7. Age (in y.	rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	SEP 5, 1	9. 1911 No	Birthplace (State or Foreign Country) rth Carolina
Tosephine		how how		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
the way	>	death with the Maryland ms 23a or 28a-f show finust be notified at	ecto	MD N/A	<u> </u>		Ba	altimore		0g. Citizen of What	1X Yes 2 □ No
026		h with 23a or 31 be r	al Dir	3504 Callaway	7 Avenue			21215			JSA
	1 98	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Madical Exacting Item collination and once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of F Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		merican Indian, /hite, etc. Black
DARGAN	21215-0036	ithin 72 hou ie. ian "natura i Madical E	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give		during most of world)	king	16b. Kind of Busine	·
7	d 21	filed within 7 Hygiene. other than "r ent, if e Med		11. 17. Father's Name (First, Middle, Last)		l D	omestic		ne (First, Middle, M	Private Maiden Sumame)	Homes
9	Maryland	Mental Mental arked o	To Be	John	Russell			Mol			unk.
2	Mar	d 2 shoth and the and traum		19a. Informant's Name/Relationship (7 Gloria G. Wells				and Number or Ru Nwav Ave		•	
kupwh	Je,	of Heal Item 2		20a. Method of Disposition	201	p. Place of Dispo				20c. Location - City	
Re	Baltimore,	ment of tant: If tant: If jury or		1 Burial 2 Tremation 3 : 4 Donation 5 Other (Specify) M			Inc. 03/1		Baltimo	
4	Ball	permit Depar Impor any in		21. Signature of Funeral Service Licen	Marthe	2	99 Frede	rick Road	l Baltin	ore, MD	of MD, Inc. 21228
		Pnysician /Medical Examiner		23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ulications that caused the done cause on each line. a	2129	er the mode of dying	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	68760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, any leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.) Due to (or as a const.) d.						7200
	P.O. Box 6	death certit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time of 9□Unknown	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
		sign d be	by	Part II. Other significant conditions of	ntributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.		~	e to the cause of death? Probably 4 Unknown
	I Reco	sician: The law requ certiticate has been rector, page 2 shoule	Completed	thypertension					24a. Was ar autopsy perform 1 Yes 2	y prior	
	Vita	Physician: r this certitic ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	her	th (Check only one		
	of	ding Physician: The n. n. After this certificate ha funeral director, page	n: To	1 Yes 22 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury	t 3□ DOA 000 28c. Injui Wo	4 ∐ Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (5 w injury occurred	Specity)
	Division of Vital Records,	To the Hospital or Attending F within 24 hours atter death. To the Funeral Director: Atter completely filled in by the funer.	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		at home, farm, str	M 1	Yes 2 □ No	28f. Location (Str. City or Town		r Rural Route Number,
	2	Hospita 24 hours Funeral etely filled	Medical C		ysician: To the best of my inar: On the basis of exam and manner stated.						
		To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens			od. Date signed (M	
		-04	nte-	30. Name and address of person who HELEN GHARV 31. Date filed (Marris 21 Year) 300	completed cause of death (item 23a) (Type,	Print) WES	P BELVE	DERE A	VE , RA	CTIMORE, MO
		Sta		MAK'1 U 20	19 Cleans	1. 100				•	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 04:40AM Lillie Pearl Davis MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMOKE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 1933 AGNES HOSPITAL 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Georgia 75 258-46-6534 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Ever sharmust by nothing at 1 ☑ Yes 2 ☐ No N/ABaltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21229 3712 Harlem Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 禁 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 ☐ Never Married 2 ☑ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Public al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Schools 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Mental and Menta Pearl Lee Willie Chastain ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6973 Rockfields Rd Baltimore, Maryland 21244 Tonya White/ Daughter Item 27 or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. Crownsville Veterals 12/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore,Md 21215 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PULMONARY Physician EMBOLISM DAY BILATERAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 XNo Ö 9 Unknown as been signed by to 2 should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by HYPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an certificate has autopsy performed? page 2 of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Division Injury 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARCH 07 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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DHMH 17 Rev 1/2001

KATIERINE

CATON

AVENUE

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BALTIMORE

MARYLAND 21229

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1620 2009 Linda M. Dennig /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Medical Center <u>Anne</u> <u>Arundel</u> 8. Date of Birth (Month, Day, May 30, 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min Months Hours 1 □ M 2 🛱 F Yrs 1943 65 Director 218**-**40**-**1836 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninar must be notified at 1 ☐Yes 2 ☐ No Director MD Stevensville Queen Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 200 Terrapin Grove #221 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XINo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify white \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) realtor property 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Newitt Hazel Elizabeth Walther ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 21619 Lisa Darden/daughter 2020 Cox Neck Road Chester, MD of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S, Wade Nortector 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 116 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 500m /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗔 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 | No hours after death. 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 26 30. Name and address of pe fson who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

MAR 1 0 2009

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month L. DORSCH GSO AM MARCH MILDRED 04 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Balto. Perry Hall 9611 F Haven Farm Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 □XF Yrs. March 16,1924 84 Maryland 217-14-5053 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Perry Hall Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9611 F Haven Farm Rd. 21128 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Balto. City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith M. Biscoe Martin W. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4718 Lavington Place Perry Hall, Md. 21128 edward C. Dorsch, Jr. Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview 3-6-2009 Balto. City 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 vein a. 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROYASCULAR ACCIDENT MINURS disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA WEEK Due to (or as a consequence of): PIASE TES MELLITUS YEARS Due to (or as a consequence of): YEARS HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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director,

To the Hospital or Attending I within 24 hours efter death.
To the Funeral Director: After

ofter death Director: /

filled

The law requires that the death certificate be executed

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Division of Vital Records,

Examiner

Physician/Medical

Completed

Medical Certification;

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 2008.

Physician

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Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

CORONARY ARTERY DISEASE, CONGESTIVE

HEART FAILURE

24a. Was an autopsy performed? 1 Yes 2 No

25. Was case referred to medical

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No

27. Manner of Death 5 Pending 2 ☐ Accident

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier (Check only one)

3 🗀 Suicide

4 - Homicide

12 Certifying Physician: To the hest of my knowledge, death optimied at the time, data and plane, and due to the neuse(s) and utancer as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Carolin C. Houk M.D.

D0051720

29c. License number

29d. Date signed (Month, Day, Year) MARCH U5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SVITE A

JOHN HOPKINSC RIVERSIDE 1321 RIVERSIDE PARKWAY BELCAMP, MD 21017

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March Doris Evans 200 /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 0201 VM O C . Age (In yrs. last birthday) If Under 1 If Under 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 □ M 2 K Months Days FEB 22 1923 245-14-9077 North Carolina 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it a five item Exx..ii wr must be rediffed at once. 1 ☐Yes 2X No Director Catonsville MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 713 Maiden Choice Lane, 2-214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph 0della Royster 19a. Informant's Name/Relationship (Type. Print)daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Hendrickson 2667 New Aspen Court, Oak Hill, VA 21071 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 03/07/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serset H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -ardiovasc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 1100 1 □ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1∐Yes 2∐N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide

law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

5-0036

2121

Baltimore, Maryland

attending physician and for use as the burial-tran cate has been signed by the page 2 should be detached To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director; After this certificate his completely filled in by the funeral director, page

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden

31. Date filed (Month, Day,

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Registrar's Signature.

Medical

State Registrar

			For State	State of Marylai		artment of rtificate of		Mental Hy	/	9 07307
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ς,	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Deat	MARC	4c. County of De	7 /
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	Funeral Director		5. Social Security Number 6. Sex 219−34−0972	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs	8. Date of Bi	nth 9. E ay, Yea <i>r)</i> 11, 1938	Birthplace (State or Foreign Country) MD
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36	be filed within 72 hours after death with the Marylar ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2☐ No If Yes, GiveΛ Year or Dates:		1□Yes 2√□No				White
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	1 and 2. Health a tem 27 Is		Mr. John J. Fishe:	r (Brother)	1		ad, Finks			
altimore,	of He of He rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b.	Place of Dispo cemetery, crei	sition (Name of matory or other pi	ace)	Date	20c. Location - City	or Town, State
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Balt	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service License	alt MOOT		Name and Add	,	ral Ho	ne Suke	BOX 195 21784
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Division or	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, office	Э	28f. Location (City or To	(Street and Number or wn, State)	Rural Route Number,
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	To the within To the Σοπτρί	Me	29b. Signature and little of certifier			29c. Licer	nse number		29d. Date signed (Mo	onth, Day, Year)
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			30. Name and address of person who co		m 23a) (Type,	Print)		-	- A	THE WO ZIZE
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DHMH 17 Rev 1/2001

			For State Registrar	tate of Marylan		artment of F rtificate of a		Mental Hy	giene Reg. No. 2	009	07308
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	Funeral		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. 53	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	lay, Year)	9. Birth	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	33	110.			1/2	23/56		MD
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	th with	ral Di	1301 Andre Street				21230		U	SA	
36	be filed within 72 hours after death with the Maryland that Hyglene. 4d other than "natural", or items 23a or 28a-f show event, the Medical Eventinar must be notified at	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2🙀 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		Race - Amer Black, White ecify:	
2-00	72 hour	ted	15. Decedent's Education (Specify only highest grade co	on .	16a. Dece	dent's Usual Occup	pation	rkina	16b. Kind of	f Business/I	ndustry
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Baltimore, Maryland 21215-0036	permit. Pages 1 a Department of Hee Important: If item any injury or othe		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ Rem- 4 □ Donation 5 □ Other (Specify)		cemetery, ciel	osition (Name of matory or other place Crematory	7 3/1	Date 7/2009	20c. Location Balt:	on - City or 1 imore	
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service Licensee	ictor P. Do	da,Jr ²	2. Name and Addre Charle I	ss of Facility L. Stever	_{ns} Funera	1 Home	, Inc.	
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	Physician		shock, or heart failure. List only one c Immediate Cause (Final disease or condition	ISUAL INTE	RSTI	TIAL P	NEUMO	AINO			Onset and Death
€2	/Medical Examiner		resulting in death)	Due to (or as a conseq ORGANIZ	uence of):	PNE	MON	IA			ZUNKNOWN
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ري ح	e law requires that the de has been signed by the e 2 should be detached	by Ph	Part II. Other significant conditions contrib	uting to death but not res	ulting in the u	nderlying cause giv	en in Part I.		_	ontribute to	the cause of death?
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isio	or Attending after death. Director: Afte in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st	M 1	Yes 2 □No	28f Location	(Street and N	mher or Ru	ıral Route Number,
Ο̈́	al or A s after il Direct	Certification: To	4 ☐ Homicide determined	building, etc. (Speci	fy)	out, ractory, office		City or To	wn, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	na Houte Harrison,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (an: To the best of my known the basis of examinant manner stated.							
	To the To the comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sig		
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8			30. Name and address of person who comp			VERSTR	EET, 31	ALTIM (DRE, N	MARYL	-AND, 21225
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2009	32. Degistrar's Signa		ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year PM 1:15 Carol A. Frank /Medical 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Samaritan Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 5,1940 Pennsylvania 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □XF Yrs **Director** 201-32-8784 68 Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits Injury or other traumatic event, the Microal Examinar must be notified at Director 1X Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3726 Elmora Avenue 21213 USA 23a Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours affe.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or it any Injury or other traumatic event Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Traffic Control <u> City Government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Frank ပ Clara Hoyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Wendler Sister 3726 Elmora Avenue Balto. Md. 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood 3-12-2009 Parkville, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CIEDIL /Medical Due to (or as a consequence of): Examiner ermonic Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy (Critical) Anemia 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

M. D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KAZORY
Cond Samaritan Hospital, 5601 Lock Raven BNJ. R.

15601

29c. License number

Res - 200

Lock Roven BN &

29d. Date signed (Month, Day, Year)

03-07

Battimore MD

			For	State of Maryla	nd / Depa	artment of H	lealth and N			
		1-	State Registrar		Cei	rtificate of	Death		Reg. No.	
Physi	laian		ecedent's Name (First, Middle, Las	t)				2. Date of De Month		3. Time of Death
Physi /Med		D.	OBERT E. FRANZ					March	5 200	
Exam	nine	4	Facility Name (If not institution, give	street and number)	*	4b. City, Town, o	r Location of Death		4c. County of	
*		S;	inai Hospital of F	saltimore	- land hinth day	Baltimor If Under 1 Year		8. Date of Bir		Birthplace (State or Foreign
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Directo	or		al Residence of Decedent							
yland now			. State 10b. County		City, Town or Lo					10d. Inside City Limits
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ified within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	Picocia	10e.	. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
th wif	-	1	1 GRISTMILL COUR	T,UNIT #406			208		USA	Ρ
rdea	Jesous II	11.1	Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race - Black,	- American Indian, White, etc.
s afte	100		1 ☐ Never Married 2 Married	1 V ∏Yes 2 ☐ No If Yes, Give		1 □Yes 2 X No	Specify:		Specify:	WHITE
hours aff	3		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Daca	dent's Usual Occup	nation		16b. Kind of Busi	ness/Industry
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Id be filk fental H ked oth	Ę		GEORGE	FRANZ			FRANCES		FINK	
s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The life with the Warylan 1 fem 27 Is marked other than "natural", or items 28a or 28a-f show other traumatic event, if a Modical Examirar must be notified at		_	a. Informant's Name/Relationship (19b. Maili	ng Address (Street		ıral Route Numb	er, City or Town, S	tate, Zip Code)
alth a		PH	HYLLIS FRANZ/WIF	E	1 GRI	STMILL C	OURT,UNIT	#406	BALTIMORE	E, MD 21208
item of He		20a	. Method of Disposition	20b	. Place of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Location - C	ity or Town, State
Page nent of			W☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				ARK 03/08	3/2009	REISTERS	TOWN,MD
permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra	ouce.	21.	Signature of Funeral Service Licen	see					SON & BRO	
2 2 2 2	됩	600	Kolich a	L	89	000 REIST	ERSTOWN F	ROAD, PI	KESVILLE	, MD 21208
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pe is		if a cau Cau tha res	quentially list conditions, n, leadin to immediate use. Enter Underlying	Due to (or as a cons	equence of):					
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the d		2	9 Unknown	9 Unknown						
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he law requires the has been signed age 2 should be considered.			when ic heart disea	.sc				1 🗆	Yes 2 No 3	B Probably 4 Unknown
law rec as bee 2 shou			honicossanchive pu	mosen dises	e_			24a. Was		ere autopsy findings available
vital necessician: The law certificate has birector, page 2 sl			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					auto perfe 1 🗆 Yes	ormed?// de	ior to completion of cause of eath? □Yes 2 ☑No
ding Physician: The In. After this certificate hit			. Was case referred to medical	-			26. Place of Dea			165 2 140
Ol Vita Physician: rthis certific ral director, I	15		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 □ DOA Ot	her: 4 \sum Nursing H	lome 5 ☐ Res	idence 6 ☐ Other	(Specify)
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r Atte	1		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	home, farm, st	reet, factory, office			Street and Number wn, State)	r or Rural Route Number,
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To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29: Medical	one)	and manner stated.		20a Lican	se number		29d Date signed	(Month, Day, Year)
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			Name and address of person who	•						
	State		Daniese. Daniese. Date filed (Month, Day, Year)	MD Sina; Ho 32. pegistrar's Sig	spital c	of Maltim	D46			
Regi			MAR 1 0 20	ng b	1 1	a del				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician CUDDY** IRVING FRIEDMAN MARCH 8 8:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EMERITUS OF PIKESVILLE PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 8. Date of Birth (Month, Day, Year) 02/03/1913 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 215-03-1044 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Pedical Examiner must be notified at Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 REISTERSTOWN ROAD 21208 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify þ If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER BAR marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) thealth and Mental Health and Mental Health and Mental Health and Mental Hem 27 is marked oth PHILLIP FRIEDMAN YETTA SZESKO ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. SHEILA MARGOLIS / DAUGHTER 2814 MARNAT ROAD, APT. E, BALTIMORE, MD 21209 20b. Place of Disposition (Name of ARL-TNGTON" CHTZUT(Name) AMUNO CONGREGATION 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/09/2009 BALTIMORE, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia ours disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: The performed? 1 ☐ Yes 2 7 No funeral director, 25. Was case referred to medical 26. Place of (Check only one) examiner? Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Man fer of Death 28h. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No 24 hours after deatl Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29b. Signature a

Registrar

31. Date filed (Month, Day, Year)

ours

30. Name

32 Registrar's Signature

INOW MED

address of person who completed cause of death (Item 23a) (Type, Print)

S WACIDON 44 Beecham Court

29c. License number

D0051896

29d. Date signed (Month, Day, Year)

Examiner P.O. Box 68760, of Vital Records, Division

or Attending Physicien: The law requires that the death certificate be executed ŏ signed by the a

Physician

/Medical

Examiner

Funeral

Director

rthan "naturel", or Iteme 23a or 28a-f sho The Medical Examinar must be notified at

or Iteme

al Hygiene.

t. Pages 1 end 2 should be filed w tment of Health and Mental Hygie tant: If item 27 le marked other to jury or other treumatic event, the

permit. Pages
Department of I
Important: If ite
eny injury or of

Physician /Medical Funeral Director

Be Completed by

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Examiner

To Be Completed by Physician/Medical

Medical Certification:

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, ŝ

> NO PITH WEST State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 054352

Percertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

> MARCH 6 2009 MITTER TODOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COURT NOAD RANDAUSTON MD 21133 HOSPITAL SHOI OLD

32. Régistrar's Signature à MAR 1 0 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March Day 2009 Marie Gingell 3:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 780 Birmingham Avenue Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAX | M 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-08-4672 1 □ M 2 🗷 F 37 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Wodes! Evan for a ust be notified at MD Baltimore Parkville Parkville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 780 Birmingham Avenue 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph С. Gingell Bernice L. Grubb ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health a Important: If item 27 is any Injury or other tranonce. 780 Birmingham Avenue, Parkville, MD Rhonda Buddenbohn - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 03/09/2009 Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funergreever reper Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Lo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause or leach line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) AMIG /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Little Uniterlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician ned for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 mor Month Year Pregnant at time of death 5 Other (specify) Ö 1 ☐ Yes 2 No 9 Unknown 9 Unknown ed by ti σ. signed by the period of the details Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use convioute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 1000 To the Hospital or Attending Physician: director, Be 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Tresidence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manne 28d. Describe how injury occurred 1 A atural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signat License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Regist<u>rar</u> 31. Date filed (Month, Day, Year)

Neil B. Rosenshein, M.D., 227 St. Paul Place, Baltimore, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Kebecca Gresham 7:17 AM 2009 March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 12 F -022 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 72 is marked other than "natural", or Items 23a or 28a-f show any hjury or other traumatic event, the Macinel Examiner must be notified at 1 ✓Yes 2 ☐ No Director D tim 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 MNo 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th grade omes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ice Nixon HO. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arrhythmia 41 hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ō Month Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Obstructive sleep 1 Yes 2 No 3 Probably 4 Unknown leted l page 2 should certificate funeral director, this After

Division of Vital Records, P.O. Box 68760,

or Attending after death filled in by the within 24 hours a

To the Funeral D Hospital completely

5					_
and moo				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
2	25. Was case referred to medical		26. Place of Dea	th (Check only one)	
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6	G ☐ Other (Specify)
and.	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(<i>Month, Day, Year</i>)	o. Time of lnjury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
200	3 Suicide 6 Could not be determined		farm, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
2	29a. Certifier 1 Certifying P	nysician: To the best of my knowled miner: On the basis of examination	lge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	e, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

RES-000

State Registrar

29b. Signature and title of certifier

30. Name and address of person who

4940 Eastern Avenue M.P. Ryan E. Stagg 31. Date filed (Month, Day, Registrar's Signature 2009

pleted cause of death (Item 23a) (Type, Print)

Baltimore, MD 21224

29d. Date signed (Month, Day, Year)

7 2009

09-01895	
Al Gaymon	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	F	- For State	Certifica	te of Death		Reg.	No. 200	9 0/31
⇔ Pkγ̃sicia Vledical Examir	n/	Decedent's Name (First, Middle,Last)				Date of Death Month Di March 6, 200	ay Year	3. Time of Death 2146 hrs
Medical Exami		$rac{ ext{A 1}}{ ext{4a. Facility Name (if not institution, give stre$	Gaymon eet and number)	4b. City, Town, o	r Location of Death	Viaicii o, 200	4c. County of Deat	
		Johns Hopkins Bayview Medic		Baltimore			a was a confid B	thplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 217-78-6185 1X M	7. Age (In yrs. last birtho	day) If Under 1 Year Months Day		5-10-	Co	mplace (State or Foreign buntry) MD
yng		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be motified at once.	Dire	10e. Street and Number 3600 Garrison E	Slvd Apt T 3	10f. Zip Code 212	15	10g.	Citizen of What Cou	ntry?
death with or items 23 must be m	Funeral	1 X Never Married 2 Married	Armed Forces? Yes 2 X No		n, Mexican, Puerto Ri		White, etc.	ican Indian, Black, Black
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121 d be fil ental F arked	Be	Al P. Gaymon, Sr		Mailing Address (Otto	Lucille			e, Zip Code). 21215
ID 2 should and M 77 is m	٤	19a. Informant's Name/Relationship (Type, Timothy Gaymon-E		3600 Garr				
e, N 1 and 2 Health item 2		20a. Method of Disposition		Disposition (Name of c ry or other place)	emetery,	Date 2	0c. Location - City o	r Town, State
MOF Pages nent of ant: If		1 XXBurial 2 Cremation 3 1 Donation 5 Other Specify:		ty Cemete		3-2009	Balto,	MD
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	2 15	21. Signature of Funeral Service Licensee	wane		North Av		Balto, M	
Physician M- dical		23a. Part I. Enter the disease, or complicat failure. List only one cause on each I	ne.		,	espiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
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e law re has be ge 2 sh	ldm					perform	ed? death?	
an: The	Be Co	25. Was case referred to medical		26.Pla	ace of Death (Check or	nly one)		
Vita	To B	1 Yes 2 No	oital: 1 Inpatient 2 ✔ ER/Ou				esidence 6 Oth	er:
on of nding P th. :: Afte e funer		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		njury at Work? 2 Yes 2 No	tou. Describe no	w injury occurred	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detact	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	rm, street, factory, office	e building, etc. 2	28f, Location (Str or Town, Sta		Rural Route Number, City
Hospi 14 hou Funer ely fil		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, dea	ith occurred at the time,	date and place, and coon, death occurred at	lue to the cause(s) and manner as st	ated. the cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of certifier	d manner stated.		ense number		29d. Date signed (M	
1. 0		Chile ?		0.0	C.M.E.		March 7, 2009	
10 pent.		30. Name and address of person who com Ana Rubio MD. Assistant		Penn Street, Baltir	nore, MD 21201			
	tate		32. Registrar's Signature	arkel				
Regis	ueu	MAIN T O COOS	MALE - 1- 17					

State of Maryland / Department of Health and Mental Hygiene 2009

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	Physicia		Decedent's Name (First, Middle, I Nancy Groves—		-			2. Date of Dea Month	ath 4, ^D 2009	Year	3. Time of Death 3:33 PM M
	/Medic Examin		4a. Facility Name (If not institution, g Dove House 292	vive street and number) Stoner Aver	nue	4b. City, Town, or Westmin	Location of Death		4c. County	of Death	1
T	Funeral Director		213-36-7965	3.77F-	e (In yrs. last birthday 69 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April	th Year) 30,1939	9. Birthp Coun Mary	lace (State or Foreign try) Land
	or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carro 10e. Street and Number		10c. City, Town or L	ter 10f. Zip Code			10g. Citizen of \	Vhat Coun	0d. Inside City Limits 1 □ Yes 🎢 ☑ No try?
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. And Mental Hygiene. I wantle event, the Medical Evaninal must be I wifed at unatic event, the Medical Evaninal must be I wifed at	Completed by Funeral Director	Dove House 292 S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest before the secondary (0-12)	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 13. 16a. Decc (Given life. 1)	Was Decedent of H If Yes, specify Cubs 1 □ Yes 2√2 No edent's Usual Occup e kind of work done of DO NOT use retired	lispanic Origin? (Span, Mexican, Puerto Specify:		14. Rac Blac Specify		e e
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Ž	s 1 and 2 should f Health and Mer item 27 is merke other traumatic	_	19a. Informant's Name/Relationship Richard Groves	(Type. Print) Son		ing Address (Street F. Stratt					
	permit. Pages 1 and Department of He Important: If item eny Injury or oth once.	ł	20a. Method of Disposition 1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Gardens	of Faith	3/7/	2009	Fullert		wn, State Maryland
Ball Rail	permit Depar Impor eny In		21. Signature of Funeral Service Lie	3. Hens	s	22. Name and Addre Burgee-He 3631 Fal	enss-Seit Is Road,	z Funera Baltimo	al Home, re, Mary	Inc Land	
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	icate be executed which physician and the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):						
O. Box 68	eath certif attending for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand	ry			te of delive	ery Day Year
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Division of	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	Certification: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no			M 1 □	ryat k? Yes 2∐No		how injury occur		
N N	ital or At irs after d ral Direct lled in by		4 ☐ Homicide determin	building, etc	ury - At home, farm, s c. <i>(Specify)</i>			City or Tov	wn, State)		il Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Ex	Physician: To the best teminer: On the basis o and manner sta	f examination and/or	investigation, in my o	opinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
	7 wit	_	29b. Signature and title of certifier	inter 1	10	D 35	_		3-0		
			JAMMO KR	on completed cause of d	55 Scritt	Calar	398 Street(UESMIN	uster ,	100	1157
	Sta Registr		31. Date filed (Month, Day, Year)	109 Admi	ar's Signature					<u> </u>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 19a per GH G889 3/17/09 WS State of Maryland Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year llaw 32 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Iniversity of Maryland edical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear Davs Hours 1 X M 2 □ F 213-46-3976 Director 08-09-1946 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It e Medical Examination and Injury or other traumatic event, It e Medical Examination and Injury or other traumatic event, It e Medical Examination and Injury or other traumatic event, It e Medical Examination and Injury or other traumatic event, It e Medical Examination and Injury or other traumatic event, It elimination and Injury or other traumatic events. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☑ No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2220 Perryman Rd 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 College (1-4or 5+) Elementary/Secondary (0-12) Commerical Waterman Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Gunther, Sr. Margaret A. Dashiell P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne G. Gunther (Wife) 2220 Perryman Rd Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If It any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gar. 03-06-2009 | Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ICIOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burlal-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate has 1 ☐ Yes_ 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AU4176435P18988

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:00 A M 2009 Roy J. Griffith, Jr. March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 Baltimore Intervale Court Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 □ F Yrs. 85 1924 **Director** 226–28–6763 March Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting must be rediffed at Baltimore Maryland Towson + XYes 2 ⋈ No Director Penslyvania Dauphin 10f. Zip Code 9 Intervale Court 322 N. 2nd Street 10g. Citizen of What Country? 21286 with -17101 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. 1nt: If Item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes. Give Specify: White ò 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Maynard Griffith Mollie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Susan Higley / Granddaughter</u> 9 Intervale Court, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Indiantown Gap National 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or 3/12/09 Annville, PA Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER OF THE PANCREAS Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be exequiced and the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗆 Yes 2 1 ☐Yes 2 ☐ No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ormick State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 10: 40 AM MARCH BUE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAN SAUSTO +COSPIT+1 BALTIMORE THWES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 03/29/1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) NJ **Funeral** Months 044-22-1917 79 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Department of Health and Mental Hygiene. Important; or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examination and the most factor and the most be notified at once. 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 904 SMOKE TREE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married WHITE Maryland 21215-0036 1 □Yes 2 No Specify 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROGRAM ANALYST SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLDFIELD SCHLAM BELLA ELLIOT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 SMOKE TREE ROAD, BALTIMORE, MD 21208 JUNE GOLDFIELD / WIFE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP: 03/06/2009 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROLNTESTI **Physician** disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54352 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCER TODO &

State Registrar 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature

NORTHWEST

DHMH 17 Rev 1/2001

RANDALLSTOUN

HOSPITAL 5401 OLD COURT ROXX

			For State Registrar	State of Ma	arylan				lealth a Death	and M		iene g. No2 ()	09	07	320
	Physici	an	1. Decedent's Name (First, Middle, Last Lisa Kay H	2. Date of De Month					Day Year						
e e	/Medic Examir		4a. Facility Name (If not institution, give	n, give street and number)				4b. City, Town, or Location of Death				March 8, 200			A. ^M
			Gilchrist Hos				Tow	son					imore		
ı	Funeral Director			7. Age		last birthday) 45 Yrs.	If Unde Months		Hours	Min.	8. Date of Birth (Month, Day, 10/16/19	Year) 963	9. Birth	nplace (State intry) . Inois	or Foreign
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside (City Limits
	Ba-f sh	Director	Maryland Howard		F	Ellicot	tt Ci	ty						1 ☐ Yes	s 2 ∑ ¶No
	th with th	ral Dire	10e. Street and Number 4937 Water Grove	Lane			10f. Zip	1043			10	Unite	ed St	ates	
036	be filed within 72 hours after death with the Maryland stal Hygiene. 9d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be netfined at	by Funeral	11. Marital Status 1 ♣ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ② ② N If Yes, Give Year or Dates:		1:	Vas Dece fYes, spe ☐Yes	cify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Ra Bla	ce - Amer ack, White,	ican Indian, etc.	
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	15. Decedent's Education (Specify only highest grade completed) y/Secondary (0-12) 12 College (1-4or 5+) 12 Electrica							Dept. of Defense Jame (First, Middle, Maiden Surname) Tetta Kay Greenley Rural Route Number, City or Town, State, Zip Code) Court Ellicott City, MD 21043 Date Ch 10, Porest Hill, Maryland Lives Funeral & Cremation Ctr., P.A. Timonium, Maryland 21093				
73	should be filed withi and Mental Hygiene. s marked other than umatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Bobby Kent Hub	bard					18. Mother	r's Name	(First, Middle, M	me)	101100		
Mary	2 shou h and M r is mar raumat	-	19a. Informant's Name/Relationship (Ty Mrs. Lisa M. Welch						and Numbe	r or Rura	Route Number,	City or Town	, State, Zi		10/0
re,	s 1 and of Healt item 2.		20a. Method of Disposition	******	20b. Pl	lace of Dispos	sition (Nar	ne of	1	Da	ate 2				21043
altimore,	t. Page tment tant: If jury or		1 ☐ Burial ②☐Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Cha	emetery, crem Vans Fi apel- k	DEST A	I r.		2009	F.C	rest H	Hill,	Maryl	.and
Ba	permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 Is marked ot any Injury or other traumatic ever		21. Signature of Furderal Service Linears	e l		Pea	Name ar acefu 23	d Addres 1 Al 25 Ye	s of Facility terna ork Ro	, tive: oad	s Funera Timoniu	ıl &Cre ım, Mai	mati Cylan	on Ctr d 2109	3,P.A.
	Dharistan		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that caused the cause on each line	the death e.	. /	^		,, 000,, 00	cardiac or	respiratory arre	st,		Interval Be	tween
	Physician /Medical Examiner		disease or condition resulting in death) a								- 0	jea	do.		
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S, T	requires that the de neen signed by the a nould be detached f	þ	Part II. Other significant conditions cor	ntributing to death but	t not resul	Iting in the un	derlying ca	ause give	n in Part I.				Month Day Year use contribute to the cause of death?		
000	req leer loor	Completed									1 ☐ Yes			ppsy findings	
Vital Records,	sician: The law s certificate has b irector, page 2 sl										autopsy perform 1 🗆 Yes 2	ed2	prior to co death? 1 🗆 Yes	mpletion of c	cause of
<u> </u>	yslcla is certi directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	nt 2 🗆 E	R/Outpatient	3 🗆 🗅 🗅	Otho			<i>(Check only one</i> e 5 ☐ Resider			Har	2-
on or	fing Ph	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	/	28b. Time of Injury	2	Bc. Injury Work?	at	28	3d. Describe how				62
IVISION	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	stigation M 1 Tyes 2 No								nber,			
_	Hospital Hospital Funeral tely filled		Check only 2 Medical Examir	sician: To the best of ner: On the basis of	examinati	vledge, death	occurred estigation	at the tim	e, date and	l place, a	nd due to the ca	use(s) and m	anner as s	stated.	2)
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			Hothy	They	c L	w	1)2	520	5	P	MARC	26, 9	, 200	9
)			30. Name and address of person who bo	(Anno	ath (Item	23a) (Type, P	rint) N-C	lin	les	St.	Balto	· and	21	20,6	
	Stat Registra	.6	31. Date filed (Month, Day, Year) - 7	09 Sener	Signatu	J. 4	alle	9							

			For State Registrar	State of	Maryland / Do	epartment Certificate			Mental Hy	giene ()	09	07321			
	Physic /Medi		1. Decedent's Name (First, Midd MURISL AN		TTUSLIAN				2. Date of De Month	ath Day	2009	3. Time of Death 09 30 A M			
	Exami	ner	4a. Facility Name (If not institution Autumn Ridge at	North Oak	s	Pike	sville			Bal	nty of Death Ltimor				
	Funeral Director		5. Social Security Number 216–12–2583 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. last birth	Months I	Days Hou	der 24 Hrs. rs Min.	8. Date of Bir (Month, Da JUN 29	1920	9. Birthy Cour Mary	place (State or Foreign ntry) land			
920	Maryland 1-f show illed at	tor	10a. State 10b. County	imore	10c. City, Town o	r Location esville		-			1	10d. Inside City Limits 1 ☐ Yes 2 No			
	th with the 23a or 28a	Funeral Director	725 Mt. Wilso	n Lane	10f. Zip Code 10g. Citize 21208						of What Cour	ntry?			
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show arcal Examiner roust be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Mar 3 ※ Widowed 4 □ Divorce	rried Armed Ford	2. K No	13. Was Deceder If Yes, specify			ecify Yes or No Rican, etc.)	i	lace - Americ lack, White, cify: Whit	etc.			
21215-0036	withIn ane. than "	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-	4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Domestic Engineer			ing		16b. Kind of Business/Industry Own Home				
Þ	should be filed of the standard Hygist marked other imatic event, It	3e	17. Father's Name (First, Middle, Abraham Chern	ey			18. M	other's Nami ary	e (First, Middle, Jacob	Maiden Sum	ame)				
, Mar	and 2 shu ealth and m 27 Is m		19a. Informant's Name/Relation: Mary Jane Snyde		er 126	ailing Address (S	rspout	Court	, Owing	ar, City or Tow S Mill	m, State, Zip .S, MD	Code) 21117			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Importent: If Item 27 Is marked any injury or other traumatic e gogs.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation '4 ☐ Donation 5 ☐ Other (5)	Specify)	cemetery,	sposition (Name crematory or othe rematory	er place)		6/2009	20c. Location Balti	n - City or To				
Ball	permit. Depart Import any inj		21. Signature of Funeral Service	ven H. Wil	liams	Cremati 299 Fre	ion Soc ederic	ciety k Road	of Mary I, Balti	land,	Inc. MD 21	L228			
	icate be executed Medical physician and physician and street street is the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a consequence of)	ili ty	of dying, such	as cardiac (or respiratory au	rest,	2	Approximate Interval Between Onset and Death			
.O. Box 68760,	The law requires that the death certificate b tie has been signed by the attending physic page 2 should be detached for use as the b		To Be Completed by Physician/Me	0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live birt	ome of pregnancy th 2 Tetal death nt at time of death	3 □Ectopic pregr 5 □ Other (specia					Pate of delive	ry Day Year	
rds, P	quires that n signed b			Part II. Other significent conditi	ons contributing to dea	th but not resulting in th	e underlying caus	se given in Pa	rt I.		bacco use co	ntribute to th	e cause of death?		
al Reco	iclan: The law requir certificate has been si rector, page 2 should I			Complete	Complete						*	24a. Was a autop perfol	SV	prior to con death?	osy findings available inpletion of cause of
Division of Vital Records,	tending Physicath. tor: After this the funeral di			25. Was case referred to medica examine:	Hospital: 1 Inp		e of 28c. y	Other: 450 Injury at Work? 1 Yes 2	Nursing Hor	me 5 Residence R	ence 6 On	urred			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		4 Homicide determ	building	est of my knowledge, d	he time, date	and place a	28f. Location (Street and Number or Rural Route Number, City or Town, State) a, and due to the cause(s) and manner as stated.							
8	To the He within 24 To the Fu	Medical	29b. Signature and title of certifie	and manne	r stated.	29c. Li	my opinion, d	leath occurre	ed at the time, o	late and place 29d. Date sign	late and place, and due to the cause(s) 19d. Date signed (Month, Day, Year)				
	Sta Registr	_	30. Name and address of person Knithesse C. 2 31. Date filed (Month, Day, Year)	who completed cause	of death (Item 23a) (Tyr AND 25 Min pistrar's Signature	pe, Print)	200 X	รรรกาง	Ran, H.	arylani	211	36			

09-01943 Glenn Maddox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 07322

		1- For State Registrar	Cert	ificate of	Death					eg. No.		
Physici		1. Decedent's Name (First, Middle,Last)		_			-	Date of Dea Month	Day Year		. Time of Death 1035 hrs
edical Exam	iner	Glenn Haddox							March 8,	4c. County of	Death	1000 1113
		4a. Facility Name (if not institution, give street and number)								tv		
		2112 Alletta Avendo							9. Date of Bi	rth (MM/DD/YYYY)		
Funeral		Social Security Number 6. Security Number			If Under 1 Months I	-	Under 2 Hours	Min.			Foreign	try) Maryland
Director	ľ	218-48-2278 1X	M 2 F	61 Yrs.					Jury	27,1947	Coun	ry) trally land
	7	Usual Residence of Decedent	Idoa City 1	Town or Location	20				-		1	0d. Inside City Limits
v an		10a. State 10b. County	- "									1 Yes 2 X No
and sho	5	Maryland Baltim	ore	Lansc		-				log. Citizen of Wha		
Maryl 28a- d at	Director	10e. Street and Number			10f. Zip Coo	L227				· ·	at Court	,,
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Ö	2112 Allett Avenu					. 0 : 1 :		-'/ - W N	USA	America	an Indian, Black,
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deat or ite	튑		1 Yes 2X No		Yes 2 X	No on	nocify:			Specify:	Whit	e
s after ral",	\$		If Yes, Give Year or Dates:	16a. Deceden				nd of wo	ork done	16b. Kind of Bus		
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36 in 72 han '	e e	. 8	conogo (v v ov o v y	Labor	er					Shippi	ng I	ndustry
With giene	6	17. Father's Name (First, Middle, Last)				18.	Mother's	Name (First, Middle,	Maiden Surname)		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. ried other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Be								y Orr			
Z = 2 = 3										mber, City or Town		
AD 2 sho 2 sho 27 is	-	Diana Haddox, W	life					Ct.		. Dundalk	., MD	21222
		20a. Method of Disposition		Place of Dispos crematory or other	ition (Name o	of cemete	ery,		Date	20c. Location -	City or T	own, State
More Pages 1 nent of H		1 Burial 2 X Cremation 3	Mot	ro Crer		Inc	. C	3/1	.0/09	Baltimo	re,	Maryland
Baltimore, permit. Pages I at Department of He Important: If ite		4 Donation 5 Other Specify 21. Signature of Funeral Service Live								land. Ir	1C .	
Balti permit. Departir Imports		Thomas Gregor	M	25	Fred	eric	k Ro	ad	Baltin	land, In more, Mar	ylar	d 21228
Physicia	1	23a. Part I. Enter the disease, or comp		. Do not enter t	he mode of d	ying, suc	ch as car	diac or	respiratory a	rrest, shock, or hea	art	Approximate Interval Between Onset and
/Medica		failure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive atherosclerotic cardiovascular disease Death										
xamine	r	or condition resulting in death)	or condition resulting in death) Due to (or as a consequence of):									
		Sequentially list conditions, b.	Due to (or as a consequence or	f).				-				160
	1	cause. Enter Underlying Cause										
ν.	Evaminer	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence or	f):								
and L												
760, cate be execute	Modical	X UNPENDED	AMENDED #1 as r	ioted, 2	Ja,21,	perm	1119 8	5002				
760, cate be			23c. If yes, outcome of preg		etal death	2	Ectopic	nreana	ncv	23d. Date of Month		ay Year
Sox 687 leath certific	or use as	past 12 months?	1 Live birth 4 Pregnant at time of de		etai deatri ther <i>(Specify</i>		Lotopio	progra	,			
Box e death o		1 Yes 2 No 9 Unknow			(101 (2) 22.)	<i>'</i>						
~ ≠ ₹.			contributing to death but not r	esulting in the	underlying ca	ause give	en in Par	t I.	- 1			he cause of death?
res that t	, page 2 snould be del											abiy 4 🗸 Unknown
rds requi	snourd									opsy	prior to co	topsy findings available on ompletion of cause of
e law	36 7 S										death?	s 2 No
tal Rec Sian: The certificate					26	.Place of	f Death (Check	only one)			
'ital sician is cen		examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DO	A Ot	ther4	Nursin	g Home 5	Residence 6	✓ Other	: Scene
Division of Vital Records, tal or Attending Physician: The law requir is after death.	ਸ਼ੂਰ ਵ	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	Injury 28	c. Injury a	at Work?	?	28d. Describ	e how injury occur	red	
anding A.	ne tur	1 X Natural 5 Pending	(Month, Day,Year)			1 Yes	s 2	No				
'isic r Atte er de	by the	2 Accident Investiga 3 Suicide 6 Could no	28e. Place of Injury - At h	nome, farm, stre	et, factory, o	office buil	lding, etc	i.		(Street and Numb , State)	per or Ru	ral Route Number, City
Division of the state of the st	filled in	1 X Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no determin							OI TOWN	, otato)		
Division o the Hospital or Attending hin 24 hours after death. the Funeral Director: Aft	2	798. Certille	cian: To the best of my knowled	dge, death occi	urred at the ti	me, date	and pla	ce, and	due to the ca	ause(s) and manne	er as state	ed.
To the To the To the	completely	(Check only 1 Certifying Physical Examination one) 2 Medical Examination one) 29b. Signature and title of certifier	er:On the basis of examination and manner stated.	and/or investig				curred a	at the time, da			
- 2	5						tense number 29d. Date signed (Month, Day, Year)					
		hy hi), m, -		,	O.C.M.	.E.			March 9, 2		
		30. Name and address of person who		m 23a)			ID 040	01		-		
				1 Penn Stre	eet, Baltim	ore, M	ער Z12	U I				
	Sta	100 11 11 11 11 11 11 11	37. Registrar's Signa	ture Sar	Ken							

		For State	State of Maryla		ertificate of				2009	07323
		Reg. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death						Reg. No.		3. Time of Death
Physic		Aston Donnell					March	Day	Year	In the BM
/Medi Examii		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Deat		4c.	2009 County of Deat	
LABIIII	iei	Sinai Hospit	al of Ball	more	Ballin	none col	y		N/A	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday		If Under 24 Hrs Hours Min.		h v. Year)	9. Birt	hplace (State or Foreign untry)
Director		213-54-1097	M 2□F 56	Yrs.					52 Ma	
and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or l	.ocation					10d. Inside City Limits
Manyti f sho led at	ō	Maryland N/A		Balti	more					1 ☐ Yes 2 ☐ No
the the 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
a or	0	3500 Ingleside	Avenue		2121	5		USA	A	
ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No	. 1	4. Race - Ame	
I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	to rican, etc.)		Black, White Specify: B1	
72 ho natur lical I	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dec	edent's Usual Occup	ation during most of wo	rkina	16b. Kir	nd of Business/	Industry
ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	9	Dwr	7 Clea:	nord
ed w ygier rt, the	ខ	12th grade		W	<u>ool Pres</u>		(F) (NA) -			mers
tally and the filed withing and Mental Hygiene. Is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last) James Howard					me <i>(First, Middle,</i> Lie Mae		. '	
should be and Mental s marked o	은		man Defeat)	10h M-1	Line Andrews (Carea					T. O. H. 2121 F
tand 2 st Health and tem 27 Is n		19a. Informant's Name/Relationship (T) Iris Beasley/ W	Vife	350	0 Ingles	ide Ave	enue Ba	ltin	nore,M	
permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, ci	oosition (Name of ematory or other place	ce) 3/1	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		cation - City or	
tmen tant:		4 □ Donation 5 □ Other (Specify)			ount Cem	i				,Maryland
permit Depar Impor any ir		21, Signature of Funeral Service License	ree .							neral Home ,Md 21215
	1	23a. Pan1. Enter the useas , or comp	lications that caused the dea						TIMOLG	
	-	Index, or hear failure. List only one cause on each line. Immediate Cause Final Interval Between Onset and Death								Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in d. th) a. Due to (or as a condition of the condition of								10 days
Examiner	ı	Sequentially list conditions	b. Disemin	ما دیا	Intrava	walay c	sugulati	on		lo days
sit 9d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):	. 0.4	way of				(-)
recute and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last C. Adult Yeyl Sahory duryey synd Due to (or as a consequence of): Due to (or as a consequence of):								10 day,
cate be executed oblysician and the burial-transit	dical E								į.	9 days
ficate g phys	edic		0	~ 0, 3	700000					
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐Ectopic pregnancy	у		2	3d. Date of deli Month	ivery Day Year
w requires that the deben signed by the should be detached	Phy		9 Unknown						se contribute to	the cause of death?
ires ti signe	by	11								obably 4 ☐Unknown
redn	sted									
e law has b	Completed	Hepatity c					24a. Was autor		24b. Were au prior to death?	topsy findings available completion of cause of
r: Th licate r, pag							1□ Yes	2 No	1 ☐ Yes	2 X No
sicial certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	7500	ent 3 DOA Oth	OF:	ath (Check only o			
ral di	<u>ا</u>	27. Manner of Death	1 ☑ inpatient 2	28b. Time	oin o 20/1	4 Li Nuising r	forme 5 ☐ Resident			cify)
ding h. Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No		,,		
deat deat ctor	fica	3 Suicide 6 Could not be	28e. Place of injury - At	home, farm, s			28f. Location (S	Street and	d Number or Ru	ıral Route Number,
al or all	Certification:	4 Homicide determined determ								
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ledical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To th within To th comp	Me	29b. Signature and title of certifier K. KUSUMA MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUSUMA KANAPARTHI MO Sina Hospita 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature MAR 1 0 2009 MAR 1 0 2009 MAR 1 0 2009						29d. Date	e signed (Monta	h, Day, Year)
		* K. Kusuma	MD		RE	5-000		M	arch 4	,2009
		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type	e, Print)	Hospel	1 . 0 0	110	- 4-	,
St	ate	31. Date filed (Month, Day, Year)	32. egistrar's Sig	nature	sing	1 103 TIEA	e of t	athi)	nore	
Regist		WAR 1 0 201	19	1. 1	rates					
		DAN A V CU		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye aı **Physician** 1220 PM Keith A. Hodges ar 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore ////
If Under 1 Year | If Under 24 Hrs.
Hours | Min. N/A Maryland 10501ta nenera Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) **Funeral** 217-66-5763 1 → M 2 □ F 50 Director 8/23/58 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD N/A Baltimore Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 E. Preston St.-Apt. 609 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African 1 Never Married 2 ☐ Married 0 21215-0036 1 ☐ Yes 2 XNo Specify Spec American þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 H&S Bakery College (1-4or 5+) Baker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, It Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elwood Hodges Connie Booth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Freda Booth?Aunt 2061 E. Belvedere Ave, Balt., MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/14/09 Balt.,MD Mt. Carmel Cem 4 Dogation 5 Dother (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Relair Rd.Balt., MD 21206-5105 Signature of Funeral Folio Dicensee 5126 Belair Rd, Balt., MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed CD57 Page 8 burial-trar resulting in death) Last Due to (or as at consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☑ No 2 No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2240 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

3

State Registrar 30 Name and address of person,

31. Date filed (Month, Day, Year)

OMON

completed cause of death (Item 23a) (Type, Print)

2

1350

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Charlotte T. Hatcher 4:00 PM March 6 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ Months Days Hours 215-34-1934 75 MD March 15 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 □Yes 2 □No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 230 Coldbrook Rd. 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Choir Director/Organist Religion/Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Charles Thompson Pauline Clarke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Hatcher/husband 230 Coldbrook Rd., Timonium, MD 21093 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/1¹7709 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Dother (Specify) 21. Signat A Fu wal Service Lic no 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) CHOLECUSTITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner The law requires that the death certificate be executed P.O. Box 68760.

2009

March 6

Division of Vital Records, Charlo #e

Physician

Examiner

Funeral

Director

s 23a or 28a-f show

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of Health of item 27 is

Department of Important: If it any injury or o once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

physician and the burial-trans attending pl After this certificate has been signed by the funeral director, page 2 should be detached or Attending after death filled in by

•	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Tho 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy successful autopsy performed? 1 □ Yes 2♥ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 XXNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify) HOSPICE
27. Manner of Leath 1 ★ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 22 Work? Injury M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	

29c. License number

D64395

29d. Date signed (Month, Day, Year)

BALTIMOTEMO 21204

State Registrar

within 24 hours a To the Funeral C Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUBERMAN, MO 31. Date filed (Month, Day, Year)

> > MAR 1 0 2009



Medica

29b. Signature and title of ca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar Month **Physician** GLORIA JEAN HANSON 2 M 4:43 2009 MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL CARROLL HOSPICE DOVE HOUSE WESTMINSTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/8/1944 9. Birthplace (State or Foreign Country)
EST VIRGINIA 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 V F 219-44-7555 64 WEST **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 No Director WESTMINSTER MD CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number and 2 should be filed within 72 hours after death with teath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or : 2524 CROSS SECTION RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NURSE HEALTH 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER JACKSON FOGLE BRUCIE EDITH BARRETT ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 8 19a. Informant's Name/Relationship (Type. PrintHUSBAND Health tem 27 i STANLEY K. HANSON, SR. 2524 CROSS SECTION RD., WESTMINSTER, permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PLEASANT VALLEY CEM. 3/7/09 PLEASANT VALLEY, 4 Donation 5 Other (Specify) 21. Signature Puneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. P. 1. Enjer he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause or a huline. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or es a consequence of) physician and s the burial-trans Due to (or as a consequence of): ical Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 2 Be Certification: To

that the death certificate be executed Box 68760. Ö Division of Vital Records, Hospital or Attending 24 hours after death.

21215-0036

Baltimore, Maryland

after death.

Director: Aff
d in by the fur 24 hours a within 2.

2

Medical

State Registrar 4 Homicide

(Check only

29a. Certifier

one)

5. Was case referred to medical			
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 🔲 🛭	00/
7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28

		. —patront — —	
Manner of Death		28a. Date of Injury	28b. Tim
→ Natural	5 Pending	(Month, Day, Year)	Inju
2 Accident	investigation		
3 Suicide	6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm

05	spital: 1 Inpatient 2[1	ER/Outpatient	3 🔲 [00/
I	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28
1				M	

28e. Place of Injury - At home, building, etc. (Specify)	farm,	street,	factory,	offic

	Thes philos philos
26. Place of Dea	th (Check only one)
Other: 4 ☐ Nursing H	ome 5☐ Residence 6 🗖 Other (Specify) Hospice
njuryat /ork? □Yes 2□No	28d. Describe how injury occurred
e	28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the best of my knowledge, death occurred at the time, date and place	, and due to the cause(s) and manner as stated.
the basis of examination and/or investigation, in my opinion, death occu	rred at the time, date and place, and due to the cause(s)

29b. Signature and tiple of certifier , Nath	nD
30. Name and address of person who completed cause of death (Item	23a) (Type, Print)

1 Certifying Physician:

2☐ Medical Examiner: On

-	DW5	953	عل
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20c License number

29d. Date signed (Month, Day,	Year)
3/4/2009	
9/1/0001	

COUPISIBNEAR C.	MAGANING	TOUR POUPE	Rel	WESTMIN STER
31. Date filed (Month, Day, Year)	32. Registrar's Signa			

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 07327 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 8:00 PM Annie Lou Horst March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Lutheran Village If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 87 vrs Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 376-14-4043 1 □ M 2 🕅 F Yrs. Director 1921 June Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Wedical Examinating that the notified at Director Carroll Westminster 1 ☐ Yes 2X No MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21158 250 St. Luke Circle, Apt 503 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u> Homemaker</u> <u> Housewife</u> Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any Injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Schaeffer William Clements 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Horst - son 370 Grey Friars Rd., Westminster, MD 21158 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State All County Cremation 3/7/09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St., Westminster, MD 21157 21. Signature of Funeral Service Licensee 254 E. Main St., Westminster, 23a. Part Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Right Lobe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lung Carcinoma Sequentially list conditions, Due to or as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ipital or Attending Physiclan: The law requires that the death certificate be executed ours after death.

eurs after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeard director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>چ</u> Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of COPD 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 🔀 No Osteoporosis 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4
Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0050763 3/7/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 826 Washington Rd. Ernesto Mendoza

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

back

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 07328 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2009 **Physician** 5, Katherine Anne House March 12:20 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hartley Hall Nursing Home Pocomoke City Worcester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 21, 1 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF 217-18-9946 87 1921 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sh Examiner must be notifled 1 ☐ Yes 2 No Director Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 782 Cedar Hall Road 21851 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ۵ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas (nmn) Bean Hilda (nmn) Gartner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 782 Cedar Hall Road, Pocomoke, Maryland, 21851 Edwin G. House / Husband Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Lutheran Cem. 3/9/2009 Joppa, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each time. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 068 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) □Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed: 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 XNo 1 Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 2XNo Other: 1 ☐ Yes ^oL 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) 054422 BARAL 10 Sarad Baral, MD 30. Name and address of person who complete oause of death (Item 28a) (Type, Print) Klacket 31. Date filed (Month, Day, 3 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:15A [™] Doris Elaine March 6, 2009 Harris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 8/28/1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 213-28-8893 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Be Completed by Funeral Director 1 □Yes 2√ No MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Othoridge Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၣ George Kocher Lillian Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Harris / Husband 17 Othoridge Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 3/9/2009 Timonium, Maryland Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, arteriosclevotic cardiovasculas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (555 W. Towsentown Bwd/Balto MD) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 2, **Physician** ^D2009 2:47 PM M Charlotte L. Hurban /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8800 Walther Blvd #4608 Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min. Hours 1 □ M 2 💢 F 030-09-8500 93 Sept 10, 1915 Massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at Director 1 ☐ Yes 2√ No MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 8800 Walther Blvd #4608 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🎇 No Specify. If Yes, Give Year or Dates: Specify: white Completed by 3 X Widowed 4 □ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 is marked other than "r Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) **12** court reporter <u>legal</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Edward Abbott Charlotte Tufts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau once. 13808 Fountain Road Ocean City, MD Priscilla Dankhoff/executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Sovice Licensee Director Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. END Immediate Cause (Final disease or condition resulting in death) **Physician** AGE week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consection of off Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the nding p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death o 9 Unknown 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops page 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To this After this funeral o 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation hours after death. neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i PRACTITIONER Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ma.	Funeral Director		373-09-7240	6. Sex 1 □ M 2 😿 F	7. Age (In yrs. la 90	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan 23,	Year) 1919	9. Birthp Cour Mic	place (State or Foreign ntry) higan	
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Ind 21215-0036 be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medikal Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	24∑ No ve		Was Deced If Yes, spec		spanic Ori n, Mexical Specify:	igin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ ack, White,		
1215-0 within 72 ho	ene. than "natur he Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us maker	rk done d e retired	lurina mos	et of work	ing	16b. Kind of		dustry	
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e, N	of Health and f item 27 Is ma r other trauma		19a. Informant's Name/Relationsh Catherine Stull 20a. Method of Disposition 1 □ Burial 2 □ Cremation	/daughter	20b. Pl		Bass	WOOC	Roa	d Fr	ederick, Date	-	21703		
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Vital Records, P.O.	icate has be	Be Completed									24a. Was a autop perfor 1□ Yes	sv	prior to cor death?	psy findings available mpletion of cause of	
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Division or Vital Records, P.O. Box 68	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical Certification:	27. Manner of De th 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could n 4 Homicide determin	ation 28e. Place	of Injury th, Day Year) e of injury - At hor ing, etc. (Specify		м		at `	No	28d. Describe h	ow injury occu	urred	il Route Number,	
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	Sta	ite	30. Name and address of person v SIBTE A. K. F. 31. Date filed (Month, Day, Year)	IZMI, H	se of death (Item	914-	Print) Toll	Ho	iust-	A	ve FR	EPERIC	CKM	021701	

DHMH 17 Rev 1/2001

D.O.D. 2/26/09

to congsician as: Hermant Dethy

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05-2009 **Physician** 13:05 Clinton Houston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death \mathbf{PG} 4b. City, Town, or Location of Death Examiner Clinton Bradford Oaks Nursing Home 8. Date of Birth (Month, Day, 0 6 – 0 6 – Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Ź8 Months Days Hours Min. 260-40-6836 Director Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Mitchellville MD PG Director 1XYes 2 □ No 10f. Zip Code 20721 10e. Street and Number 10g. Citizen of What Country? 23a or 1509 Kingshill St. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? KAS \— 1 MYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian XYes 2 Yes, Give 1 Never Married 2 Married 6 Specify: Black 1 ☐ Yes 2 ☐ XNo Specify: <u>8</u> 3 Widowed 4 Divorced "natural", Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Item Additionals." (Give kind of work done during most of working life. DO NOT use retired) Sollege (1-4or 5+) Elementary/Secondary (0-12) Four Seasons Banquet Captain 18. Mother's Name *(First, Middle, Maiden Surname)*Prookie Thomas 17. Father's Name (First, Middle, Last) Be Luther Houston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Kingshill St. Mitchellville, MD 20721 Deborah Houston-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-13-09 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. ature of Funeral Service Licenses 22. Name and Address of Facility Ronald Taylor II FH travol 10583 Middleport Ln. White Plains, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIWans 154A I disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or se's consequence of) Exami Due to (or as a consequence of) edical as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2/2 No 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed sician and burial-trans physician attending sign be director

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Medical Certific

Division of Vital Records, P.O. Box 68760 After **Hospital or Attending** 24 hours after death. filled in by the completely

State Registrar

within 2 To the I

25. Was case referred to medical examiner?

3 Suicide

29a. Certifier

4 | Homicide

(Check only

29b. Signature and title of cert

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending

☐ Could not be determined

investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 □ No

Other:

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number

dical Examiner: Of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name an address of who completed cause of death (Item 23a) (Type, Print)

			For State	State of		nd / Depa		nt of H	lealth and	Mental Hy	/gien	900		07333
			Registrar 1. Decedent's Name (First, Middle)	Last)			inoa		Journ	2. Date of De	Reg. No). L. O C		3. Time of Death
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	Funeral			6. Sex	7. Age (In yrs.	-	If Unde Months	r 1 Year	If Under 24 Hr.		rth av Year	g.	Birthplac Country	ce (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County		10c, Ci	ity, Town or Lo	cation						10d	. Inside City Limits
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Maryland 21215-0036	iges 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If item 27 Is marked other than "natur or other traumatic event, It. Medical	100	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address	s (Street a	and Number or F	Pural Route Numb	er, City	or Town, Sta	te, Zip C	ode)
	and lealth m 27 her tr		Susie H. Haub	/_Wife		102	211 G	ary]	Road, Po	tomac, 1				
Baltimore,	ges 1 It of H If itel or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	B □ Removal from S	State Dot	Place of Dispo cemetery, cren comac Un	sition (Name	me of other place	9)	Date	20c. L	ocation - City	or Town	n, State
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Division of	Hospital or Attending Physician: 24 hours after death: Funeral Director: After this certifics etely filled in by the funeral director; p	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place (of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	eet, factory	, office		28f. Location (; City or Tox	Street ar vn, State	d Number or	Rural R	oute Number,
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			30. Name and address of person w				,							
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State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03-04-2009 **Physician** 4:45a ^M Thelma V. Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Future Care Sandtown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 08–20–1922 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 214-20-9762 86 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment reast be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Eutaw Place Apt 821 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: African American Š 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) House Keeper Maryland Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Gross Bertha Maxfield ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ardella Witherspoon/Daughter 1701 Eutaw Place Apt 821 Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 03-09-2009 Baltimore, MD re of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Wheet 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** KAVENOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ysician and The law requires that the death certificate be execu Due to (or as a consequence of) attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 → No Month Day Year 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 🗆 No 2 2/40 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10059107 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN 31. Date filed (Month, Day, Year) State Registrar MAR 1 0 2009

			For State Registrar	S	tate of	f Maryla	nd / Depa <i>Cei</i>	ertment of <i>tificate o</i>			-	giene Reg. No	71111	9 (7335
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	Francis		BON SECOUR 5. Social Security Number	6. Sex	SPI		s. last birthday)	If Under 1 Yea	ar If Unde	er 24 Hrs.	8 Date of Bir	th	9. E	Birthplace	(State or Foreign
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Euzene Physician 10100 AM Jones March 5 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Care Center Ba Year If Under 24 Hrs. If Under 1 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days XXM 2□F 12-24-1949 Virgin Island Director 59 580-093936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County My Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 1618 Normal Avenue 21213 USA an "natural", or items 23a Medical Examiner must t Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1x X es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify:Black 1 ☐ Yes 🍇 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the Disabled Disabled unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Be Nieresta Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Ellen Davis Jones-Wife 1618 Normal Avenue Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 3-11-2009 Owings Mills, MD Garrison Forest 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H lady 1101 E. North Avenue Balto, MD 21202 wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhand Gastrointe **Physician** minutes /Medical Due to (or as a consequence of) **Examiner** uremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examine renal tailure Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ hemorrhage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performe death? 2 No 2.0 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed burial-trar Box 68760. attending physic for use as the b P.O. Records, certificate has Division or Vital ospital or Attending Physhours after death.
uneral Director: After this ly filled in by the funeral di

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than '

6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

29c. License number D04383

29d. Date signed (Month, Day, Year) March 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Boy view Circle W. B. Greenoish H. D. Ralt more no 21 224

State Registrar

Medical

31. Date filed (Month, Day, Year)



To the Hospital o within 24 hours aft To the Funeral Di

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16a per fh g889 3-10-09 vt. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 15 AM marc Jeorge 009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Baltimore Park Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F 85 Months Days Hours Min. 218-18-2916 7/3/23 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and it fiem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a broughed show that the item of the traumatic event, I'm I'm fractical Evaluation and the profiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore **Funeral Director** Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3611 Park Heights Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12 Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No Specify: Specify: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by If Yes, Give 1943-5 Specify. 3 Widowed 4 □ Divorced Ämerican 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Mail Elementary/Secondary (0-12) College (1-4or 5+) US Post Office Carrier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LURIN Clayton Thomas Jackson ဥ 19a. Informant's Name/Relationship (*Type. Print*)

Juanita Hall/Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Park Heights Ave, Balt., MD 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Garrison Forest va 3/12/09 N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owinds Mills, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHari P. Close F. Sys. PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fune al Service License 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ETASTA **Physician** disease or condition resulting in death) COLON o months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Box 68760-Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide (x) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES

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BALTIMORE

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Veal **Physician** Walter Eugene Kitner 219 MARCH 2009 09:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Joseph Medical Center Saint If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 207-22-0085 79 Millersburg Director 22,1929 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Pedical Examinar must be notified at Baltimore Director MD Baltimore 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1838 Wycliffe Road 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 No
If Yes, Give Korean
Year or Dates: 10, 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🛛 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Production Scheduler is marked other 17. Father's Name (First, Middle, Last)
Russell Kitner 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be facent of Health and Mental Myrtle Danley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1838 Wycliffe Road Paltimore, MD 21234 . 27 Mary Kitner/ Wife other permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. timore, 20b. Place of Disposition (Name of E valifs, Furbinal of There) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Forest Hill, MD 4 □ Donation 5 □ Other (Specify) Bel Air 21. Sig a ure of Funeral Service Licensee Evals Fuleral Capel & Cremation Services - Parkville 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to for as a consequence off any, togating to immusic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28a 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier elle 00 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76.711 Signature OSLER DRIVE TOWSON MARYLAND 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3 2009 3:49 Pearl E. Kade 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Keswick Multi-Care Center Baltimore Birthplace (State or Foreign Country)
 SC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 1/29/1922) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 M F 87 215-24-9193 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or items 23a or 28a-f show 10b. County n/a 10c. City, Town or Location 10d. Inside City Limits 10a, State ¶ Yes 2 No s 23a or 28a-f sh Director M) Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must 4728 Amberlev Avenue Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 ☒ No specify: African - American Specify δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Damestic 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Kade Bell Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3939 Setonhurst Road Pikesville, Maryland 21208 Russell Willard / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park 3/14/2009 Paltimore, Maryland ^{22. Name and Address of Facility} Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 21. Signature of Funeral Service Licen 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical as for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypothyroidis perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/08 3 D0054056 Daljeet Sayand

Registrar DHMH 17 Rev 1/2001

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ad address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0139 AM David W. Kulick MARC 05 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALT AGNES Imork If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr. 13, 1964 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 44 Connecticut 218-90-1125 Director Usual Residence of Decedent 10d. Inside City Limits 10b Counts 10c. City. Town or Location 10a. State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Examinating rust be notified at MD Baltimore Director Baltimore 1 ☐ Yes 2 🙀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4715 Washington Blvd. 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Roofer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone. August L. Kulick Magdalene Kolumban 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel M. Kulick - Brother 6440 Ryan Avenue, Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 ☐ Burial A☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3-7-2009 Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. Surface of Fun Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Imonaru 100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to for as a consequence of: Examin and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months?
1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate 1 □ Yes 2 1 NG 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1☑ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mayorler of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? or Attending Natural 5 Pending after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Caton Ave Battimore MD21229 agres 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 07341 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03-06-2009 **Physician** 1000 A M Elizabeth Joel Kempton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bel Air Health & Rehab. Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–16–1926 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours Min. 1 ☐ M 2 🗓 F Yrs 158-20-0689 82 Conn. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 705 Compass Rd Apt. 204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify: White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Ira D. Joel Mildred Luce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Kempton (Son) 1401 Balsam Ct. Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4 □ Donation 5 □ Other (Specify) 03-07-2009 Baltimore, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee MacPhail Rd Bel Air, MD 21014 610 W. 23a. First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on suse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mopt 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed

Physician /Medical Examiner

Funeral

Director

28a-f show

6

23a

or items

al Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I

the Medical Examiner rust be notified at

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

3altimore,

Box 68760.

P.O.

of Vital Records,

Division

or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-trans has

Be Completed by 25. Was case

Medical Certification: To

examiner?

27, Mann Death

atural 2 Accident Matural

4 T Homicide

(Check only one)

29b. Signature and title of certifier

and address of person who

3 ☐ Suicide

29a. Certifier

1 Yes 2 No

Director: / death filled in by within 24 hours a

State

Registrar

31. Date filed (Month, Day,

5 | Pending investigation

6 ☐ Could not be

determined

Hospital:

1 ☐ Inpatient

28a. Date of Injury (Month, Day, Year)

mpleted dause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

1 ☐ Yes

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

2 No

28d. Describe how injury occurred

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

4 Nursing Home

2 □ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles Millard LaPorte, Jr. 2009 12:01 PM March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare Chesapeake Arnold Anne Arundel 8. Date of Birth (Month, Day, Nov 23, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □XM 2 □ F Months Days Hours Min 89 Yrs **218-10-**0368 Maryland Director 1919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "hodical Eventine" is ust be notified at Director 1 ☐ Yes 2 No Anne Arundel Severna Park Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21146 USA 286 North Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No 1942 If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status within 72 hours after Never Married 2 ☐ Married 2□No 1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify. White ğ 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumation. Draftsman Johns Hopkins Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie M. UNK. Charles Millard LaPorte, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 290 North Drive Severna Park, Maryland 21146 P.R. Beigel, Jr., Stepson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 03/06/09 Baltimore, Maryland 21. Signature of Funeral Service Licenses
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eavs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a P.0. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, \$ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to edica examiner? Be 26. Place of th (Check only or Other: 1 | Yes 2 | □ | N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dir completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signati and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 LARRIMORE Month **Physician** MARCH 12:18A /Medical 4b City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner MediCAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F APR 8 1955 216-54-2742 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1X Yes 2 □ No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 1619 Malvern Street 21224 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≜ Yes 2 □ No If Yes, Give Year or Dates:1972-75 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status e filed within 72 hours after de Hygiene. Other than "natural", or item Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: White ۵ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Sparrows Point permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Larrimore Yvonne Fetterhoff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Mitchell - sister 836 Middlesex Road, Essex, Maryland 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 03/09/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H Name and Address of Facility Cremation Society of Maryland, Inc. Williams HA 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEAR /Medical Due to for as a consequence of): Examiner Vear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

ADRIENNE 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

10 NORTH GREENEST

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #10c PET fh 8889 3/10/09 Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day :08 **Physician** Jacqueline Louise Ligon-Howard 2009 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JAMARITHN HOSDITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07–08–1962 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 215-86-2179 46 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State items 23a or 28a-f show Iner must be notified at Mills **Owings** 1 ☐ Yes 2 No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9430 Fitzharding Lane 21117 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indian, 11. Marital Status item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Black, White, etc. 1 and 2 should be filed within 72 hours affer. Health and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married 1 □ Yes 2 No Specify: Specify African American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8th tal Hygiene. College (1-4or 5+) NCIA File Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles Delaware Mary Joyce Ligon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9430 Fitzharding Lane Owings Mills, MD 21117 Brian Howard/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F tant: If ite 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department Important: If any Injury o Mt. Zion 03-11-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to or as a conse uence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 page certificate 1□ Yes or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 XER/Outpatient 3 DOA ٩ After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident Injury 5 Pending the Funeral Director: After and the fundately filled in by the fundately fi 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH MAMEDOV BALTIMORE 21239 MD MOSPITAL 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month S COM A 12:75PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BAUTIMONE, M 402P1782 SECOUNS N/AIf Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2√2 F 82 1926 Maryland 217-20-0326 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21223 USA 400 Millington Avenue Apt. 308 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married SpecifBlack 1 ∐Yes 21 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private Industry 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Lipscomb Sarah Sadler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 513 W. Seminary Ave Lutherville, Maryland Lauretta Evans/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/09 Dundalk, Maryland Carmel Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Fugeral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is incident Evarinet must be notified at any injury or other traumatic event, it is incident.

Baltimore, Maryland 21215-0036

/Medical

the attending physician and hed for use as the burial-tran been signed by the should be detached cate has b page 2 sl After thi funeral of

The law requires that the death certificate be executed

certificate |

this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending Physician;

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	- hone c	ancer	Onset and Death		
Sequentially list conditions, if any could be transfer or the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cue to (or as a consequence of): C. Due to (or as a consequence of): d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions	s contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2			
25. Was case referred to medical		26. Place of Dea	ath (Check only one)			
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	e 6 ☐ Other (Specify)		
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No				
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t, factory, office	28f. Location (Street City or Town, St	eet and Number or Rural Route Number, State)		
	Physician: To the best of my knowledge, death aminer: On the basis of examination and/or inveand manner stated.					
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)		

State Registrar

31. Date filed (Month, Day,

Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ELTON 5:04p^M RONNIE LOVE March 6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 XXM 2 □ F Director 70 FEB. 13 1939 238-56-3890 NORTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MARYLAND BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 1303 QUEENS PURCHASE RD 21221 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 61/64 or items, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. ģ 3 ☐ Widowed 4 Divorced Specify: BLACK "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within 7 of Health and Mental Hygiene. item 27 is marked other than "n other traumattc event, the Multi College (1-4or 5+) Elementary/Secondary (0-12) FURNITURE 10th grade WAREHOUSEMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ JAMES EXUM LOVE GENEVA WOODS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other trong. Wilma L. Love-Jordan/Daughter 710 Benninghause Rd., Baltimore, Maryland 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 03-12-09 OWINGS MILLS, MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician RAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed g Y burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No 1 □Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 24 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I hours after death uneral Director: 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the within 2 29b. Signature and title of certifier 29c. License number 25205 . Charles St. Balto. and 2120x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 620 Date filed (Month, Day, Year) 32/Registrar's Signature State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 2:00 PM MAR 01, 2009 DOUGLAS R. LOMBARD, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL 101 MARTIN RD. 8. Date of Birth (Month, Day, Year)
JULY 6, 193 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**XX**M 2□ F Months Days Hours Min. VERMONT Director 009.16.3452 75 1933 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its "Modical Extra in its the notified at Director 1 □ Yes 2VX No GLEN BURNIE MD ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral death v 101 MARTIN RD. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: WRITE Specify: b 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION ENGINEES WASHINGTON METRO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h pe RILEY LOMBARD INFT ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is WIFE 101 MARTIN RD., GLEN BURNIE, MD 21061 BARBARA LOMBARD permit. Pages 1 and Department of He Important; If iten any injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State BAYVIEW CREMATORY, INC 4 ☐ Donation 5 ☐ Other (Specify) MAR 4, 2009 of Funeral Service Licen 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. CREGORY FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 23a. Part | . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or andition resulting in th) CARDIOPULMONARY FAILURE **Physician** /Medical Due to (or as a consequence of): 19 YEARS Examiner DISEASE ART BRY CORONARY Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician the burial Physician/Medical as pulpu IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death atter for u 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the o 9 Unknown 9 Unknown detach ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ MELLITUS aig be IABETES 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To hours after death.

Ineral Director: After this
y filled in by the funeral dii 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03-03-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 888 BESTGATE ROAD, SUITE 211, ANNAPOUS MD 21401 K. ESSANDOH, MO 31. Date filed (Month, Day,- Year) State S. Jak Registrar

			1 - For State Registrar	State of Ma	ryland /		artment of I		nd Mental Hy	_	2009	07368		
			1. Decedent's Name (First, Middle, Las	t)			- Invocato or	Dodin	2. Date of De	Reg. No	0.2000	3. Time of Death		
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Sea of Sea	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of D		40	c. County of Death			
	-		Shady Grove Adver	ntist Hosp	ital		Rockv				Montgome			
	Funeral Director		5. Social Security Number 6. Se	Лм 21€7 F	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days		Min. (Month, D	ay, Year	Cot	nplace (State or Foreign untry)		
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	rylan show	_	10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limits		
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	with the	Ö	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?		
	eath v	eral	405 Farragut Avenu	ue 12. Was Decedent E	vor in II C	10.1	208		0./0:6	Uni	ted Stat			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experience must be notified at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			rvas Decedent of F f Yes, specify Cub 1 □ Yes 2 🖾 No	an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.))-	14. Race - Amer Black, White, Specify:	etc.		
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S	nd 2 salth ar		Charles S. King/ 1	•					Rockvill					
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and a	Physician		Immediate Cause (Final disease or condition resulting in death)	a. D.	lumer	1.9.						Onset and Death		
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O. Box	that the death certificated by the attending posterior detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death		Ectopic pregnanc Other (specify)	у		000	23d. Date of deliv Month	ery Day Year		
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			30. Name and address of person who co		,		,							
	Ctor	0	Payam Chini, M.D. 31. Date filed (Month, Day, Year)	9901 Medic	al Cen	ter	Drive, R	ockvill	le, Maryla	ind_	20851			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01691 2009 07349 Latitia Nichole Gaines State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Latitia Nichole Lewis 2. Date of Death Physician/ Month Day February 27, 2009 0829 hrs Medical Examiner Gaines Lowis Latitia -N-4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham Doctor's Commuity Hospital 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MD Months Days Hours Min 01 - 31 - 1971217-86-1303 38 Country) Director M 2X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No Lanham PG 28a-f show death with the Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number notified at 20706 9340 Washington Blvd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married 1 Never Married Yes Black Specify If Yes, Give Year Yes 2 X No specify: 3 Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) mit. Pages 1 and 2 should be fited within 72 Prpartment of Health and Mental Hygiene.
portant: If item 27 is marked other than "r
jury or other traumatic event, the Medical E Child Care Provider Private 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rhonda Marie Fisher Be Gaines Lonnie Jerome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9340 Washington Blvd Lanham, MD 20706 2 Sean L. Lewis-Husband 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Riverdale Pk. Burial 2 X Cremation 3 Removal from State 3-10-09 Riverdale, MD Crem Other Specify. Donation 5 22. Name and Address of FacilityRonald Taylor II FH 21. Signature of Funeral Service Licenses 10583 Middlepart Ln. White Plains, MD analo Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medital Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enjer Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and X_{AMENDED} #1, 23a,27,perME, G890 4/2/09 TT sician/Medical XUNPENDED tending physician use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy . Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ≥ 1 Yes 2 ✔ No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 2 No No 1 V Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient DOA 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year After 28b. Time of Injury 27. Manner of Death Certification: Yo the Funeral Director:
To the Funeral Director:

To the Funeral Director: 1 X Natural Yes 2 No 5 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

Nyente

Margarita Korell MD.

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signature 1 send

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Medical

29d. Date signed (Month, Day, Year)

February 28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March Day 2009 3:27p 5 Agnes Malanowski Physician Josephine 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carrol1 Westminster Carroll Hospice Dove House Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec 3 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours 1912 **Funeral** 1 □ M 2 □ ₹ Yrs 96 215-09-6293 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou amortant: If item 27 is marked other than "natural", or items 23a or 28a-f should provide the control of th "natural", or items 23a or 28a-f show Eldersburg Carroll MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 1810 F Vincenza Drive 14. Race - American Indian, Black, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Specify: white Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) domestic College (1-4or 5+) Elementary/Secondary (0-12) homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine D'lugasz Tsidor Mik 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Piney Creek Ct., Monkton, MD 21111 David Powell (son-in-law) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition . 1☑ Burial 2☐ Cremation 3☐ Removal from State Dundalk, MD Holy Rosary Cemetery 3-10-09 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dage Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy Year 23b. Was decedent pregnant 3 Ectopic pregnancy Day 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 □ Yes 2 ☑ No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ģ plnods Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s 2 1NO 2 ₽No 1 ☐ Yes 1 🗌 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? eral Director: After this certific filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Fother (Specify) ASPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 TYes Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death i or Attending F s after death. I Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral C Hospital 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier (Check only one) 29d. Date signed/Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jungsur, FREE 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) 1000 LiBARTY FD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10e, I per Ih, 8889, 03/10/09dhb 7,8 For Amend Item 29c State of Maryland Despating Health and Mental Hygiene 2 State Registrar amend #20b Per fH G889 3/20/69 tiffe ate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 13:57 09 lason \supset terbert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner imor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace Country) 5. Social Security Number Age (In yrs. last birthday) Funeral Days Months Hours 1 M M 2□ F 09/28/1924 84 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a State ral", or items 23a or 28a-f shov Exercities 1.00 1 XYes 2 □ No Director imore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ 3 ☑ Widowed 4 □ Divorced ac "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Patapsco bore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 6hnSon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (niece) ¥ Irene Dallo 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in Jury or Greenmount Crematory 3/27/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Horse. Balto. W. North Ave. 2222 23a. Par 1. Enter the displace, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown has been signed by e 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autonsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 N 1 ☐ Yes 1 2 inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27, Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P21070 2009 30. Name and address of person who comp of death (Item 23a) (Type, Print) 2120 22 S. LEEDOM State 9 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:35 A M STANCIL Mcnair Jr MARCH OX 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 7 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□ F 1956 MD Director 219-62-6872 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinations to mother at Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 21213 USA 2851 Lake Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2 XNo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stancil McNair, Sr Clotelia Robertson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edith L. McNair-Wife 2851 Lake Avenue Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Pk 3-13-2009 Randallstown, 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue lade Balto, MD 21202 woun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory **Physician** FAIWRE DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ONE MONTH NEMMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 □Yes 2 1 NG 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DDA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ... To the Hose.
... within 24 hours after us...
To the Funeral Director: After the Funeral properties of the funeral with the funeral properties of the funeral with the funeral properties of the fune 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signafure and title of certifier Merigin 14=5-000 MARCH, 08, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE, MD 21224 VERONIQUE NUSSENBLATT M.D. 32. Fegistrar's Signature State Registra

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Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01487 State of Maryland / Department of Health and Mental Hygiene Deborah Mitchell 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 20, 2009 0058 hrs Medical Examiner DEBORAH MITCHELL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Randallstown **Baltimore County** Northwest Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex **Funeral** Hours Director JAN 28, 1971 Country) NY, NY 2XXF 38 130.56.2432 M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XX Yes 2 No 28a-f show NEW YORK NEW YORK 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 10025 ā 250 RIVERSIDE DR. **APT.23** Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Yes 2XX No Widowed 4XX Divorced If Yes, Give Year Yes 2 XX No specify: Specify: WHITE þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **21215-0036** ould be filed within 72 LIVERY OWNER and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ADRIENE WALLACH MARTIN S. MITCHELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is 2 31 LENOX RD., ROCKVILLE CENTRE, NY SISTER REBECCA MITCHELL es I and 2 of Health a 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Removal from State Burial 2 XX Cremation 3 (ant: BAYWEW CREMATORY INC. FEB 23, 2009 BALTIMORE, MD Other Speedy: 22. PANKING ONERAL FROME, P.A. The funeral Service Licer 426 CRAIN HWY. S., GLEN BURNIE, MD CREGORY, FINK M01148 Part I. Enter the disease omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death ate Cause (Final disease a Quetiapine intoxication xaminer or con vion resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical 23a,27,28a-f, perME, G889 3/11/09 TT attending physician a X UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> О φ Yes 2 V No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 1 🗸 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: Natural subject ingested drug Division Yes 2X No Pending Director: Fd 2/19/09 unk Accident Investigation è 28f. Location (Street and Number or Rural Route Number, City or Town State) 4188 Adrienne Way Randallstown, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc X Suicide 3 Could not be or Town State) 4188 Randallstown, home determined To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ▼ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 20, 2009 0

State Registrar Laron Locke MD. Assistar

Registrar's Signature & Sanks

111 Penn Street, Baltimore, MD 21201

38. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar 07354 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Month **Physician** O T 2009 05:41 PM Augustine B. Melvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Agnes N/A Himore. If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 8/23/39 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 216-36-7139 69 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show other traumatic event, the Medical Examinar must be notified at MD N/ABaltimore TEYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21215 2501 Violet Ave- Apt. 404North USA or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: American þ 3 ₩ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'y any injury or other traumatic event, It a IN 3 gones. Elementary/Secondary (0-12) College (1-4or 5+) Self Homemaker 11 17. Father's Name (First, Middle, Last)
Willis Telp, Sr 18. Mother's Name (First, Middle, Maiden Surname) Ruth Sykes Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Violet Ave-Apt. 404N, Balt., MD 21215 Annie Melvin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem 20c. Location - City or Town, State 3 / 1 4 / 0 9 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service Licenses 5126 Belair Rd, Balt., MD 21206-5105 Close F. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart lailure. List only one cause on each line cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Stage Di Lak **Physician** Kenal 460m disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner DIDIOMYON CAPS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): pertension The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): 68760; Mellitus Physician/Medical C04 signed by the attending be detached for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has birector, page 2 s 24a. Was an autopsy performed? Yes 2001No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: After this c funeral dire Certification: To 1 Ses 2 No 1 Dopatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title N/I 17 30 335878 3 who completed cause of death (Item 23a) (Type, Print) 900 Coton Avenue Boltimore MD 21229 Maria del Pilar Moroles 31. Date filed (Month, Day, -Year) State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 9,2009 **Physician** 3:58A Ethel Juanita Morris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford BelAir Upper Chesapeake Hospital 8. Date of Birth (Month, Day, Year) March 30,1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days West Virginia 1 □ M 2 1 F 83 235-36-7152 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination ust be notified at 1 ☐ Yes 2 No Funeral Director Kingsville Balto. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21087 USA 10804 Pfeffers Rd. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married land 21215-0036 1 ☐ Yes 2 🛣 No Specify White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Annie Simmons Denny Hollandsworth မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health at Important: If item 27 Is any Injury or other trau 10804 Pfeffers Rd. Kingsville, Md. 21087 John W. Morris Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood 3-12-2009 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bacteremia **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia UNKNOWN Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Morris, Ethe! M80050591/ Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ You 3 ☐ Probably 4 ☐ Unknown ischemia icate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of Fibrillation Atrial autopsy death? 1 ☐ Yes 2 ☐ No performed within 24 hours after death.

To the Funeral Director: After this certificate the Funeral director, page Hypoxe mia 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ➡npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03,09,2009 D0065421 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive, Bel Air, Maryland Fistler, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Morris,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per FH g889 3 724/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 11:35PM Mary Blocher Neill /Medical March 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7207 Exeter Road Bethesda If Under 1 Year | If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 578-46-1495 Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours Min. Director 082-24-1122 January 15, 1935 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Pedical Examinar must be notified Director 1 ∐ Yes 2 ⊠ No Maryland Montgomery <u>Bethesda</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 7207 Exeter Road Funeral 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify þ Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other the 4 Teacher Schoo1 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Blocher Josephine Vivian Wildman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is i any injury or other trau once. John B. Neill/ <u>5303 Springlake Way, Baltimore, Maryland 21212</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate
Of Heaven Cemeter 20a. Method of Disposition Date 20c. Location - City or Town, State aven Cemetery 10, 2009 Silver Spring, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heaven Cemetery 21. Signature of Funeral Service Licensee M00335 M00335 | Bethesda, Mary1and 20814-350 |
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760 Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Pulmonary Embolus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy page certificate 2 X No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check one) 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) H50128 March 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Richard Morrison, D.O. 5410 Connecticut Avenue N.W. #103 Washington, D.C. 20015

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 0 2009

Registrar

State

31. Date filed (Month,

21215-0036

Maryland

Baltimore.

NAR 1 0 2009 32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 8A 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign (In yrs. last birthday) If Under Social Security Number Age Funera! Days Hours Min MARYL 1 ☐ M 2 🛛 F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a State Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [V]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumath. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WT Specify \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Keeper Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State -2009 EVANS FUNERAL CHARES-AIR 3-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 8800 HARFORD RICHD FARKVILLE, IN 21. Signature of Funeral Service Licensee EVANSTUNERAL CHAPEL 23a. Part 1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer of unlenoun origin 6 months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 eral Director. After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 **Z**No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 1 🗆 Yes 2 🗆 No or Attending Physician: PAUGHTER 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD March 9, 2004 20063610 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) A Riverside Pkuy Belcamp MD 21017 Howard Yana 1321 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Reg. No. 2 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Gordon 12:48 PM March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner J.M. Pearce Koac Monkton der 1 Year | If Under 24 Hrs. Saltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**□**M 2□ F Months Days Hours Min Monkton, Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified Director Monktor 1 ☐ Yes 2 TUNO immore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 211 U.S.A 23a Funeral 72 hours after death items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Dres 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 1 No Specify: Specify: Whit ģ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within a nent of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) illage INN ana 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If i any injury or Injury or 1 ☐ Burial 2 ☑ Cremation -2000 4 ☐ Donation 5 ☐ Other (Specify) ntlay 22. Name and Address of Facility Evans Funeral Chape 21. Signature of Funeral Service Licensee Monkton mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown has been ba 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: 2 Accident 1 ☐ Yes 2 □ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29c. License number
D0038968 29b. Signatur 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 2360 W. Joppa Ro Suito 306 Lutter

30. Name and address of person who completed cause of death (Item 23a) (Thanks a. Winterwitz MD)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a &26te Per Physics 888 began in the alth and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7, 2009 10:30PM 20 /Medical 4a. Facility Name (If not institution, give street and number) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 F 225-96-4725 Florida Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination and once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) xver employed 17. Father's Name (First, Middle, Last) ပ 19a. Informant's N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) we BAlto. MD 2120 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of isposition \ 1 Burial 2 □ Cremation 3 □ H 4 □ Donation 5 □ Other (Specify) 2 Cremation 3 Removal from State NH.ZionCe 21. Signature of Funeral Service Licensee asso 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melasi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Juanan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jua to (or se a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No mente 24a. Was an autopsy performed 1 □Yes 2 □No 25. Was case referred to medical examiner? Nephew's Res 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no D Swaraman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4340 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State	of Mary		rtment of	Health and f Death	Mental Hy	giene Reg. No.2	009	0736	2
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death	
	Physicia		William Mic	hael P	ierce	ے			March	7 7	2009	10:33 p ^M	1
1	/Medic Examin		4a. Facility Name (If not institution,			<u> </u>	4b. City, Town,	or Location of Deat		4c. Cou	nty of Death		
	Lxamiii	GI	1926 Harewood F	Road			Edgew	rood		Har	rford		
Т	Funeral		5. Social Security Number	6. Sex	7. Age (Ir.	yrs. last birthday)	If Under 1 Yea	r If Under 24 Hrs		rth	9. Birthp	place (State or Foreig	n
	Director		215-92-5949	1 ⊠ M 2□ F	44	Yrs.	Months Day	s Hours Will.	02/18		Cour	MD	
	p .		Usual Residence of Decedent		140	60. T						Od Inelde City I look	
	show	_	10a. State 10b. County MD Harf	ord	10	c. City, Town or Lo		rewood				0d. Inside City Limits 1XYes 2 □ No	
	Ba-f s	Director											
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evanture must be notified at		10e. Street and Number 1926 Harewood	l Road			10f. Zip Code 210			10g. Citizen d	of What Cour ISA	itry?	
	death ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Vas Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No)- 14, F	Race - Americ		\neg
ဖွ	or ite		1 ☐ Never Married 2 ☐ Marrie		2X No		□Yes 2 XN		to riloan, otc.)	Spe	Black, White, o	iite	
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N T	Hygie Hygie Ther 1	ပိ	12 17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (Fjrst, Middle	. Maiden Surn	name)		\dashv
Maryland 21215-0036	d be fi ental l ced of	Be c	Leroy L. Piero	ce				Jacq	uelene	Smith			
Σ	s 1 and 2 should of Health and Mer item 27 is marke other traumatic	잍	19a. Informant's Name/Relationsh	in (Type, Print)		19b. Mailir	a Address (Stre	et and Number or R	ural Route Numb	er. Citv or Tov	vn. State. Zio	(Code)	
	12 s th an	0 0	Leonard Pierce		er	11	-	od Road, E				•	
ā,	thealth tem 27 i		20a. Method of Disposition		2	Ob. Place of Dispo	sition (Name of	(200)	Date	20c. Locatio	on - City or To	wn, State	_
9	Pages nent of I ant: If ite		1 ☐ Burial 2 XX cremation 4 ☐ Donation 5 ☐ Other (Sp			Ardent C			/2009	Hanov	ær, M)	
altimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.	- (5	21. Signature of Funeral Service L	icensee Dor	ota Ma	rshall 22	. Name and Add	ress of Facility	an Com				
m	P E E G	0 ()	Dondo	No M	ous	w	Maryiar PO Box	1413, Bal	.on serv .timore,	MD 212	203		- 1
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the	death. Do not ent						Approximate Interval Between	
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	/Medical		resulting in death)	Due t	o (or as a co	nsequence of):						_	
	Examiner		Sequentially list conditions	b									
	pe sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due t	o (or as a co	nsequence of):							
	and and I-tran	Examiner	that initiated events resulting in death) Last	c	n (or as a co	nsequence of):					-		-
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687	ficate phys s the	edical		d						-			_
X	leath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o						23d.	Date of delive	ery	ļ
Box	death e atte d for	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4 □ Pre	gnant at tim] Ectopic pregna] Other <i>(specify)</i>				Month	Day Year	1
P. 0.	at the de by the tached	hys	9 Unknown	9 □ Un	known								_
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Division of Vital Records,	or At ifter d Direct in by	Certification: To	4 Homicide determi	ned 286. Pla	ce of Injury - Iding, etc. (S	At home, farm, str Specify)	eet, factory, offic	e		'Street and Nu wn, State)	mber or Rura	Al Route Number,	
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	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier			1	29c. Lice	nse number		29d. Date s	ned (Mbnth,	Day, Year)	\neg
			N ola	-				D0056	449	31	910	9	
			Name and address of person	who completed ca	use of death	(Item 23a) (Type,	Print)	0) 0			11.1	1	
_ (V	(oloria Sim	onsa	2M	DIIIW.	High	Dt. Du	ite 30	コナ	Kton	MD 219	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Harley Н. Perkins. Jr. March 2009 7:17 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center **Baltimore** Towson Social Security Number 7. Age (In yrs. last birthday) 73 Yrs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Min. 042-32-0850 May 9, 1935 Connecticut Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Cockeysville 1 ☐ Yes 2 X No 10e. Street and Number 19 Sunnyvale Court 10f. Zip Code 10g. Citizen of What Country? 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced . 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Cemeterv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harley H. Perkins, Sr. Marie O'Connell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Perkins / Wife 19 Sunnyvale Court, Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Hilltop Service Corp. 03-09-2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signat Funeral Service Licensee 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aspiration proumonia Due to or as a consequence of): altered mentation Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ruptured gortic anaugem Due to (or as a consequence of): yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

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permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other irans

Baltimore, Maryland 21215-0036

/Medical

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physician and s the burial-trans as attending ası ĺ the detached þ signed I peen has certificate this After thi

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

the Hospital or Attending Physician:

in 24 hours area the Funeral Director: Af anletely filled in by the fu

completely

within 2

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27, Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29a, Certifier

24a. Was an autopsy performed? Yes 2000 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 🗆 No 1 ☐ Yes

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number 00060567

29d. Date signed (Month. Day, Year) March 4, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) May joy Gonzales Mejia North chaves stree Baltimore land 21204

31. Date filed (Month, Day, Year) State Registrar

		For State Registrar	State of	Marylan		artment of l ertificate of			iene eg. No. 2 (ากจ	0.7	36
		1. Decedent's Name (First, Middle, I	ast)					2. Date of Deat	h Day	Year	3. Time of	Death
Physicia /Medic		Burnett Alexand	er Pettit	Sr.				Month March		009	5:53	A^{M}
Examin		4a. Facility Name (If not institution, g	ive street and num	ber)		4b. City, Town, o	r Location of Death	h	4c. Count	y of Death	-/	
		Stella Maris				Timor	nium			Balt:	imore	
Funeral Director		5. Social Security Number 6. 212–07–9936	Sex 1 x M 2 □ F	7. Age (In yrs. 94	last birthday Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 4	Year) 1915	Cou	place (State ontry) yland	or Foreigi
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8a-f	Director	Maryland Baltin	nore		Timoni					<u> </u>		ZIXINO
D or		10e. Street and Number		226	_	10f. Zip Code		,	0g. Citizen of		ntry?	
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d other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, I'm Maclical Evit: item roust bu multiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give	ces? 2 <mark>∏</mark> No e	.5. 13.	Was Decedent of HIf Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)		ack, White,	can Indian, etc. nite	
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Department of Heath and Mer Important; If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship	(Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ıral Route Number	City or Town	n, State, Zip	o Code)	
n 27 n 27 ier tr		David C. Page	Son-in-		4026	Holly Kn	oll Drive	e, Glen <i>A</i>	rm, MI	210)57	
i je i		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	□ Bormovot from S	20b. F	Place of Dispermetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location	- City or To	own, State	
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eral Direct	Certific	3 □ Suicide 6 □ Could not 4 □ Homicide determine	28e. Place o building	of Injury - At hogg, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Num State)	ber or Rura	al Route Numi	ber,
he Fun pletely	edical	one X Nurse Prac	aminer: On the bas	sis of examina	wledge, dea tion and/or in	th occurred at the ti nvestigation, in my o	me, date and place ppinion, death occu	, and due to the carred at the time, da	tuse(s) and mate and place,	anner as s	stated. the cause(s))
70 TOO	Σ	29b. Signature and title of certifier	ISLAM	IP		29c. Licens	e number 19792	29	d. Date signe	ZOC	Day, Year)	
4		30. Name and address of person wh		10.5					-1-1			
		JACKIE JONES, CR 31. Date filed (Month, Day, Year)	NP 2300	DULANE Strar Signa	Y VALI	LEY RD.	TIMONIUM,	MD 2109	3			
Stat		und mod (month, bay, real)	2009 32. Re	Jana d	1	backer						
Registra	:II	MAKIU	ZUUY /	we will	10. 17							

State of Maryland / Department of Health and Mental Hygiene ? 1 9 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9 2<u>009</u> Month **Physician** 8:00a March Sara Rogers Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6261 Tamar Drive Howard Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours 245-32-6929 1 □ M 2 💢 F 84 Months Davs MAR 8 1925 North Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County : I and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. I Health and Sa or 28a-f show tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Evanties must be redflied at 1 ☐ Yes 2 XNo Director Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 6261 Tamar Drive USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes X No Specify: If Yes, Give Year or Dates Completed by Specify: 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Rogers Willi Boone ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Renee Rogers - daughter 6261 Tamar Drive, Columbia, MD 21045 permit. Pages 1 a
Department of Her
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematorty, Inc03/09/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams ²²Cremation Factoriety of Maryland, 299 Frederick Road, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Parknson's 15e45e /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Cluse as or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical the as attending for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>^</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 □ Nursing Home 5 🗷 Residence 6 □ Other (Specify) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident 5 Pending after death.

Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled i Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certifier n3530G 319109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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Rogers,

Ellicott

850 N Ridge RJ

Sattin

MAR 1 0 2009

Sandra 31. Date filed (Month, Day, Year)

Division of Vital Records. P.O. Box 68760.

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/Medic Examin Funeral Director		4a. Facility Name (If not institution, g Manor Care - 5. Social Security Number 106-32-1547	- Rossvil	le e (In yrs. last birti		4b. City, Town, or Ros If Under 1 Year Months Days	sville If Under 24 Hrs Hours Min	8. Date of Bi	rth ay Ye ar)	Baltim 9. Birth	place (State or Foreign
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72 hours after death with the Maryland natural",or items 23a or 28a-f show dical Evaminar must be notified at	Funeral Director	10e. Street and Number 3047 Soundi 11. Marital Status	ng Drive 12. Was Decedent Armed Forces?	Ever in U.S.		10f. Zip Code	21040 lispanic Origin? (: an, Mexican, Puer	Specify Yes or Noto Rican, etc.)		tizen of What Cour USA 14. Race - Americ Black, White,	can Indian,
i within 72 hours after species of the "ratural", or the "ratural", or the Medical Example.	Completed by F	1 Never Married 2 Married 3 Widowed 4 Provioced 15. Decedent's (Specify only highest of	If Yes, Give Year or Dates:	16a.	Decede	□ Yes 2 🛣 No ent's Usual Occup ind of work done O NOT use retired	Specify: pation during most of wo	orking	16b. K	Specify: B	Lack
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and 2 shoul salth and M 27 is mar er traumat		19a. Informant's Name/Relationship Jennifer Jon		I .	_		and Number or R	lural Route Numb	ber, City	or Town, State, Zip	*
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ite be executed ysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of):									
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		Physician: To the best aminer: On the basis o and manner st	f examination and			ppinion, death occ		, date an		o the cause(s)
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Registr	_	MAR 1 0 20	109 Series	J.	par	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Ky'Leigh Madison Rogers 2009 07367 1- For State Certificate of Death

		Registrar			Certi	ilicate of	Deam			.Re	eg. No.	L., O	0 2	0 1 0 0
Physicia edical Exami		1. Decedent's Name Ky lei	gh Madis	son Roger	S				l N	Date of Deat Month Jarch 3, 2	Day	Year		of Death 30 hrs
\mathcal{C}		4a. Facility Name (i Carroll Hosp	_	street and number)		ľ	Westminster		Death :			ounty of D	eath	
Funeral Director		5. Social Security N	1_	x 7. Age	(In yrs. las	t birthday) Yrs	If Under 1 Year Months Day 8 3		1	Date of Bird June 3		9.008	Birthplace (Country)	State or Foreign
<u> </u>		Usual Residence of 10a. State	Decedent 10b. County		On City T	own or Locati							140-1-1-	aida Oika kimika
Aaryland 28a-f show auy 1 at once.	or	MD	Carrol1			esvill								side City Limits Yes 2 X No
the Mary! a or 28a-l	Director	10e. Street and Nur 912 Care		****			10f. Zip Code 21784			10	0 ₉ . Citizer US.	of What (Country?	
215-0036 be filted within 72 hours after death with the Maryland ntal Hygiene rked otter than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Marrie	ed 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2	ver in U.S.		s Decedent of His es, specify Cubar				- 14	Race - A	merican Indi c.	an, Black,
s after	by F	3 Widowed		If Yes, Give Year			Yes 2 X No				ل		oi rac	ial
5-0036 led within 72 hours Hygiene other than "natur	Completed	Elementary/Seco		ly highest grade comp College (1-4 or 5-		during m	t's Usual Occupa ost of working life	DO NOT L		done	16b. Kin		ess/Industry	
5-0036 led within 7/ Hygiene other than	omp	17. Father's Name ((First Middle 1 and)			nev	er worke		/F:			none		
21215-0036 Suld be filed within 7 Mental Hygiene marked other than it event, the Medica	Be	Charles	Allan I	Rogers				Ang	s Name (Firs gela M	Marie	Mabe	,		
e, MD 2 Land 2 shoul Health and M item 27 is m	To	19a. Informant's Na Angela M.	Mabe (mo			912 C	Address (Stree aren Dr	., Syk					itate, Zip Co	de)
Baltimore, permit Pages I an Department of Ilea Important: If iter		20a. Method of Disp 1 Burial 2		Removal from State	. cre	ematory or oth	ition (Name of ce ier place)	,	Da		1	-	y or Town, S	
Fages Pages Taut: If i		4 Donation 5	Other Specify:		All		y Cremat		3-8-0		_		1e, M	
Sykesvil Burial 2 X Cremation 3 Removal from State All County Cremation 3-8-09 Sykesvil Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home When I was a specific to the specify: 22. Name and Address of Facility Haight Funeral Home P.O. Box 195, Sykesville, MD 21784										apel				
Physician		23a. Part I. Enter th	e disease, or compli	idetions that caused th										oximate Interval
/Medical Examiner		failure. List onl Immediate Cause (I or condition resultin	1 1 11 1	Multiple Injuries									Betw	een Onset and Death
		Sequentially list cor	- L	Oue to (or as a conseq	uence of):									
	iner	if any, leading to im cause. Enter Under	mediate E rlying Cause	Due to (or as a conseq	uence of):									
uted d ansit	Examiner	events resulting in (Due to (or as a conseq	uence of):									
Sox 68760, death certificate be executed to a strending physician and J for use as the burial - transit	an/Medical	UNPENDED		AMENDED						_				
68760, certificate be iding physici	/Me	IF FEMALE: 23b. Was decedent	prognant in the	23c. If yes, outcome	of pregna	ncy		_	- Vis		23d. E	Date of deli	very	
certifi	cian	past 12 months		1 Live birth 4 Pregnant at til	ne of death	, =	al death 3	Ectopic	pregnancy		Me	onth	Day	Year
Box: death of the attented for us	Physici	1 Yes 2 🗸 N	lo 9 Unknown	9 Unknown		5 Otr	ner (Specify)							
of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate this certificate has been signed by the attending lumeral director, page 2 should be detached for use as I	by Pi	Part II. Other signif	ficant conditions	contributing to death t	out not resu	ulting in the u	nderlying cause	given in Par	t I.				e to the caus	
duires	ted							· · · · · · · ·	— ļ	24a. Was a				Unknown dings available
COFC	Completed		 				_			autop:	sy		to completion	on of cause of
Re I: The inficate		25. Was case refern	ed to medical				OS Plans	e of Death (Charle anti-	1 Y Yes :	2 No	1 🗸	Yes	2 No
/ital	Be	examiner?	_	ospital: 1 Inpatient	2 ✓ E	R/Outpatient		Other:	Nursing Ho		Residence	- 6 0	ther:	
n of \ ding Phy After th	7: To	27. Manner of Death		28a. Date of Injury	2	8b. Time of Ir		ry at Work?	28d.	. Describe h	now injury	har-a		
	atio	1 Natural 2 Accident	5 Pending Investigatio	Mar 3, 2009	'' c	0000 hrs	1	Yes 2 🗸 I	No Sub	ject assa	aulted			
Division of Vital Records, pital or Attending Physician: The law requirement after death. In the control of th	ertific	3 Suicide 4 Homicide	6 Could not b determined	28e Place of Injur			t, factory, office b	ouilding, etc.		Location (S or Town, St Caren Dri	Street and tate)	Number or	Rural Route	e Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical Certification:	29a. Certifier 1	Medical Examiner:	n: To the best of my li On the basis of exami	nowledge,	death occurr			e, and due	to the cause	e(s) and n	nanner as :	stated.	s)
F S	Be	29b. Signature and t		and manner stated.			29 c. Licens	e number			29d. Dat	e signed (Month, Day,	Year)
		MI	14	RIZ			0.0.	M.E.			March	4, 2009)	<u></u>
		Russell Alex	ander MD.	ompleted cause of dea	Examir	ner 111	Penn Street,	Baltimor	e, MD 2	1201				
Sta Regist		31. Date filed (Monti	h, Day, Year) NR 1 0 200	32. Registrar's			Kal							

			For State of 1 - State Registrar	-	epartment of H Certificate of L		-	giene Reg. No.2	009	07368
	Physici		1. Decedent's Name (First, Middle, Last) Dallie G. Ruther	ford Jr.			2. Date of De Month	ath Day	Year 2009	3. Time of Death
0	/Medic Examin		4a. Facility Name (If not institution, give street and num BALTIMORE WASHINGTOL M 5. Social Security Number 16. Sex	EDICAL CE	STER GL	Location of Death	LDIE	4c. Coi	unty of Death	RUNDEL
	Funeral Director		5. Social Security Number 229-50-7767 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last birtl 70 y	rs. Months Days	Hours Min.	8. Date of Bir	39 ^{ar)}	Cou	ntry) VA
	Maryland -1 show	tor	10a. State 10b. County MD Anne Arunde1	10c. City, Town	or Location n Burnie					10d. Inside City Limits 1 □Yes 2 ☒ No
	with the 3a or 28a	I Director	10e. Street and Number 100 Buckingham Dr.		10f. Zip Code 2106	1		10g. Citizen USA	of What Cou	ntry?
36. 36.	be filed within 72 hours after death with the Maryland nital Hygiene. Id other than "natural", or items 23a or 28a-f show event, If a Medical Exp. in act must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decer Armed For 1 Meyes If Yes, Give Year or Da	2 □ No	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White, ecify: whit	etc.
ALLIE (d within 72 hou giene. er than "nature tre Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-12)	1or 5+)	l Decedent's Usual Occupa (Give kind of work done o life. DO NOT use retired, [echanic	ation luring most of workii)	ng	16b. Kind o Dove: Will:		dustry
land -	4 = V E	To Be C	17. Father's Name (First, Middle, Last) Dallie G. Rutherford Sr	•		18. Mother's Name Grace	(First, Middle,	Maiden Sur	name)	
HORD,	and 2 sho lealth and I m 27 Is ma		19a. Informant's Name/Relationship <i>(Type. Print)</i> Mrs Betty J Rutherford/wi	fe 19b.	Mailing Address (Street a	and Number or Rura m Dr Glen	al Route Numbe Burnie	er, City or To	wn, State, Zip 1061	o Code)
Ruther Jord Baltimore, Mary	Pages 1 nent of H int: If Ite iry or otl		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of crematory or other place Crematory	3/9/2	2009		on - City or To ville	
Ball	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee	м01364	22. Name and Addres	s of FacilityKirk Hwy SE Glo	ley-Ruc en Burn	ldick ie MD	Funera 21061	1 Home PA
	Physician		23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition	ch line.			or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (c	r as a consequence of	EPS15 NELMON	·A				
V	rcuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequence of	r):					
8760,	icate be executed physician and ; the burial-transit	dical Ex		r as a consequence of	n):					
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	in the past 12 months?	ome of pregnancy rth 2 Fetal death int at time of death wn	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d.	Date of delive Month	ery Day Year
	w requires that the d been signed by the should be detached	ed by PI	Part II. Other significant conditions contributing to dea	th but not resulting in	the underlying cause give	n in Part I.			ontribute to the	ne cause of death?
Division of Vital Records,	r: The law re icate has be r, page 2 sho						24a. Was a autop perfor 1 □ Yes	sy	prior to con death?	psy findings available mpletion of cause of
of Vit	Physician: r this certific ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ In	patient 2 ER/Outp	patient 3 DOA Othe	26. Place of Death r: 4 ☐ Nursing Hor			Other (Specif	iy)
ion o	Attending P or death. ector: After t by the funera	ation:	2 Accident investigation		ury Work	at ? ′es 2 □No	28d. Describe h	ow injury occ	curred	
Divis	tal or Atturs after de al Directo	Certification: To	3 Suicide 6 Could not be determined 28e. Place of building	f Injury - At home, farr g, etc. <i>(Specify)</i>	n, street, factory, office	2	28f. Location (S City or Tow	Street and Nu n, State)	mber or Rura	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	sis of examination and	death occurred at the tim /or investigation, in my op	e, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and date and plac	i manner as s ce, and due to	stated. the cause(s)
	D THE PLANT	Σ	29b. Signature and title of certifier	li	29c. License			_	ined (Month,)	Day, Year) 4, 2009
			BALTIMOZE W	of death (Item 23a) (T JASA. 767	ype, Print) MCDI	05370	NOR			
	Star Registra	-	31. Date filed (Month, Day, Year) MAR 1 0 2009	gistrar's Signature	als					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

dwii itoseiiaiai		tment of Health and Mental F ificate of Death	Reg. No. 200	9 0736
Physician	1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examine	Dawn Rosentha1 4a. Facility Name (if not institution, give street and number)	I the City Town and postion of Dan	February 26, 2009	1630 hrs
	5172 Wright Avneue	4b. City, Town, or Location of Deal Baltimote	th 4c. County of Dea	tn
Funeral . Director	5. Social Security Number 219-66-8805 6. Sex 1 M 2 F 51	t birthday) If Under 1 Year If Under 24Hi Months Days Hours Mi		
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
ě .	Balt Balt	timore		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once		10f. Zip Code 21205	10g. Citizen of What Co USA	untry?
within 72 hours after death with the Maryland before. We stan "natural", or items 23a or 28a-f state at once we have been at the notified at once or manifed by Elinoral Discontinuation of the control		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No specify:		rican Indian, Black, te
5-0036 ed within 72 hours. eg within 72 hours. other than "natur: the Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		Industry unk
OO36 Within 72 giene. her than " Medical I	12 4 17. Father's Name (First, Middle, Last)	ironworker	e (First, Middle, Maiden Surname)	
21215-0036 ould be filed within 7 but Mental Hygiene. s marked other than ic event, the Medica			eth Biedenbach	
Should is man aftic ev	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or		
e, MD 2 l and 2 shou Health and N item 27 is n Traumatic	Nicole Jacobs/daughter 20a. Method of Disposition 20b. Pla	5172 Wright Avenue Face of Disposition (Name of cemetery,	Baltimore, MD 2120 Date 20c. Location - City of	
MOF Pages ent of nt: If	1 Burial 2 Cremation 3 Removal from State cre 4 X Donation 5 Other Specify:	ematory or other place)		
Baltin permit, Departm Importa	21. Signature of Fundral Service Licens and Director	22. Name and Address of Facility State Anatomy Boar Baltimore MD 217	cd 655 W. Baltimore	Street
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.			Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Cardiomegaly Due to (or as a consequence of):			Death
led Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted		N TILL	
executed an and al - transit				
760, frate be executed g physician and the burial - transit	X UNPENDED AMENDED 23a,27,p	erME, g889 3/30/09 TT		
x 68 h certif	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death g Unknown	2 Fetal death 3 Ectopic pregr	23d. Date of delive Month	ry Day Year
P.O. Boys in the deating and by the attended for edetached for the physical		ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
ords, P.C. v requires that s been signed should be deta			24a. Was an 24b. Were a	utopsy findings available
Records, The law requires freate has been sig			performed? death?	completion of cause of
tal Rection: The certificate ector, page	, 25. Was case referred to medical	26.Place of Death (Check		es 2 No
Vital I hysician: this certification of the Country	1 Yes 2 No Inpatient 2 E	R/Outpatient 3 DOA Other Nursi	ng Home 5 Residence 6 🗸 Othe	er; Scene
Division of Vital Records, rat or Attending Physician: The law require as ther death. In Director: After this certificate has been sited in by the funeral director, page 2 should be refification: To Re Commission	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 2 Accident Investigation	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	3 Suicide 6 Could not be determined (Specify)	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Functal Director: completely filled in by the	1 24a Certifier			
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo February 27, 20	
	30. Name and address of person who completed cause of death (Item 23 Zabiullah Ali, M.D. Assistant Medical Examiner	^{3a)} 111 Penn Street, Baltimore, MD 2	1201	
Stat Registra		base		-
DHMH 17 Rev 1/2001	MAR I U ZOOS /CO	ORIGINAL		

				· •	Black Indelible Ink.	•	•	
			For State Registrar	State of Marylar	nd / Department of H Certificate of D		Reg. No. 2009	07370
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	ABISTON		2. Date of Month	Death Day Year	3. Time of Death
À	Examin Funeral	er	4a. Facility Name (If not institution, give st	7. Age (In yrs.	4b. City, Town, or Asst birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Hours Min.	Birth Pay, Year, O So	hplace (State or Foreign
	Director Month		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location		16, 1911 1111A	10d. Inside City Limits
	th the Mary or 28a-f sh e notified	Director	MARYUAND BAUTI MON	RE TI	MONIUM 10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2 ☑ No untry?
9	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Everiner rust be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Ame Black, White	
21215-0036	thin 72 hours e. an "natural", Medical Eva	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educing (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates: ation	16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ation Juring most of working	16b. Kind of Business/	Industry
Maryland 21	should be filed wir and Mental Hygien s marked other th umatic event, Ins	To Be Con	17. Father's Name (First, Middle, Last)	MAN	HUVIOVITIVO	18. Mother's Name (First, Mid.	<u>VW \\ NOUV</u> dle, Maiden Surname) {\ O T	10
	1 and 2 sho Health and em 27 is me ther traums		19a. Informant's Name/Relationship (Type SAB STON) 20a. Method of Disposition	1-SON 20b.	19b. Mailing Address (Street at 3108 A NORTH M	and Number or Flural Route Nu.	mber, City or Town, State, 2 CTWORE, MA 20c. Location - City or	AYLAND 2123
Baltimore,	permit. Pages Department of Important: If it any Injury or o		1 M Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State	22. Name and Addres	17 TO 00	PHAKIN (UE 1 PRO FOAD HAKKI REMATION SE	1
1	Physician		23a. Part 1. Enter the disease, or complice shock, or hart failure. List only one Immediate Cause (Final disease or condition resulting in death)		th. Do not enter the mode of dying		y arrest,	Approximate Interval Between Onset and Death
,60,	Medical Examiner bhysician and the burial-transit	al Examiner	Sequentially list conditions, if any reading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to (or as a consection).	plained of):			
O. Box 68760,	ath certifi attending or use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	ac. If yes, outcome of pregring 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 Ectopic pregnancy		23d. Date of del Month	livery Day Year
rds, P.	quires that the de en signed by the a uld be detached f	by	Part II. Other significant conditions conf	tributing to death but not res	sulting in the underlying cause give		vid tobacco use contribute to Yes 2 □ No 3 □ Pr	o the cause of death? robably 4 \(\) Unknown
of Vital Records,	ding Physician: The law requir h. After this certificate has been s funeral director, page 2 should	Completed				pe	Vas an utopsy erformed? 1 □ Yes	utopsy findings available completion of cause of
Vit	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatient 2 ☐	BR/Outpatient 3 DOA Othe	26. Place of Death (Check on er: 4 ☐ Nursing Home 5 ☐ R		city) HOSPICE
Division of	ending Physath. or: After thinhe funeral	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury 28c. Injury Work		be how injury occurred	IIOSI TOE
Ω̈́	= 5 # c		4 ☐ Homicide determined	building, etc. (Spec		City or	n (Street and Number or Ri Town, State)	
	o the Hospital or thin 24 hours afte the Funeral Dire	Medical		er: On the basis of examin	owledge, death occurred at the tin ation and/or investigation, in my op			
D	To the within 2	M	29b. Signature and the of certifier	SLANP	29c. License	9792	29d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who con JACKIE JONES, CRI	NP 2300 DUL	ANEY VALLEY RD.	TIMONIUM, MD	21093	
H	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's Sign	Statistics and the state of the			
DH	MH 17 Rev 1/2		MAK I U ZUK	13 phone	p. Marke			

	_	For State Registrar	State of Maryland		rtment of F			giene Reg. No. 2 (009	07371	
		Negistrar Name (First, Middle, Las	t)				2. Date of Dea	ıth		3. Time of Death	
Physicia /Medic		Lois E. Sout	herland				March 8	, 2009	Year	2:45 P. M	
Examin	er	4a. Facility Name (If not institution, give Upper Chesapeake M			4b. City, Town, or Bel Ai	r Location of Death T			nty of Death rford		
Funeral Director		5. Social Security Number 6. Security Number 11	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birtl (Month, Day July 3,	y, Yea <i>r</i>)	9. Birthp Coul Michi		
p >		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	eation				11	0d. Inside City Limits	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hydiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Micrical Examiner must be notified at once.	ctor	10a. State 10b. County Maryland Harfor		ngdon	Jacon					1 □Yes 2 □No	
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country? United States			
s 23a		612 W. Baker Av		140 4	21009	lianania Origina (Ca			ean Indian,		
iter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼No	s. 13. y	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	В	etc.		
urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	□Yes 2M2No	Specify:		Spe	te		
"natur	Completed	15. Decedent's Ed (Specify only highest grad		16a. Deced (Give I	lent's Usual Occup kind of work done	nation during most of work d)	ing	16b. Kind of	dustry		
l withii giene. r than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		urse	,		Healt	hcare		
e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surn	ame)		
Ment Ment arked atic e	To B	Fred Riddle		Υ		Irene St					
2 shc h and r Is m		19a. Informant's Name/Relationship (7				and Number or Rui					
1 and Healt em 27		Jerry L. Southera 20a. Method of Disposition	20b. Pl	ace of Dispos	Baker A		ngdon, I	Maryla 20c. Locatio		009 own, State	
Pages ment of ant: If it ury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donarton 5 ☐ Other (Specify	Removal from State Eval	metery crem ns Fun Bel Ai	eral Cha	pel Marc 20	h 10,	Forest	Hill,	Maryland	
permit. Depart Import any Inj once.		21. Signature of Funeral Service Licen	see	22 E V	Name and Addre	ral Chape	l & Cre	mation	Servi	ces-BelAir	
		23a. Part 1. Enter the disease, or compshock, or heart failure. List only	lications that caused the death	. Do not ente	Newport er the mode of dyir	D TIVE FO ng, such as cardiac	rest H1. or respiratory ar	rest, Ma	ryland	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Chronic Ol	Gstm	ictive 1	Pulmon	an D	il e aye	· +	Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a consequ							3 0	
pe at	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ence of):							
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	ence of):							
ficate be ex physician a s the burial-			.d								
ertifica ing ph	Medi	IF FEMALE:									
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ 10	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	у ————————————————————————————————————			Date of deliv Month	ery Day Year	
at the de by the tached	hysi	9 Unknown	9 Unknown								
es that igned I be det	by P	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.	_/			he cause of death?	
w require been signatures							1 12	/es 2 □ No	3 □ Pro	bably 4 Unknown	
e faw r has be ge 2 sh	Completed						24a. Was autop	osy	prior to co	ppsy findings available impletion of cause of	
sician: The certificate I rector, page							1 Yes	rmed? 2 DNo	death? 1 ☐ Yes	2 🗆 No	
hysician: his certific	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Oth	26. Place of Dea			211 - 42		
Physer this eral di	J: To	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of			ome 5 ☐ Resid 28d. Describe h			fy)	
nding Fath. r: After re funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		k?]Yes 2 □ No					
To the Hospital or Attending Physician: within Fut hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director, it	Certification:	3 Sulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tox		mber or Run	al Route Number,	
ospital hours uneral ly filled			ysîcian: To the best of my know								
the H(iin 24 ihe Fi.	Medical	one)	niner: On the basis of examinat and manner stated.	uon and/or in							
Nith Vith Som	Σ	29b. Signature and title of certifier	- 111		29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

1106 K

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) k ammdim Milliaus Hig II

31. Date filed (Month, Day, Year) AAR 1 0 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 200° Juanita May Shaffer 7:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Chesapeake Future Care Arnold Anne Arundel 8. Date of Birth (Month, Day, Year) July 16, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months Days Hours Min. 79 236-46-1208 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or Items 23a or 28a-f show 10a, State 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Arnold 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 305 College Parkway 21012 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No White ð Specify. 3X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hostess Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Smallwood Ruth Kelican 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If Item 27 is any Injury or other tra Richard W. Shaffer, Son 5332 4th. Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 03/06/09 Baltimore, Maryland 21. Signature of Funeral Service Licenses Cremation Society Of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE END) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,☆ Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed s certificate has be lirector, page 2 sl 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No autonsy perforr 1 ☐ Yes r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No ပု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: / 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C nuh 31. Date filed (Month, Day, Yea State

DHMH 17 Rev 1/2001

Registrar

Physicia /Medica Examine **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriner; out by nutilied at once.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1215-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NICOLE Edmond, MD 4940 Eastern A Baltimore MD 21224 4940 Eastern Ave 31. Date filed (Month, Day, Year) 37. Registrar's Signature State MAR 1 0 2009 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

March

6,2009

٠	1 - For State Registrar		, ,	Cer	tificate of	Death		R	eg. No.	CUU	0/3/
	Decedent's Name (First, Middle, Last	43. *					2.	Date of Deat Month	h Day	Year	3. Time of Death
n I	Norman R	Simor	}					March	06	2009	1006 PM
r	4a. Facility Name (If not institution, give				4b. City, Town, or Baltimo		eath		4c. Cour	nty of Death	
	Johns Hopkins F 5. Social Security Number 6. Se	buy view	(In yrs. last	birthday)	If Under 1 Year	-	Irs. 8.	Date of Birth	1	9. Birthp	place (State or Foreign
		Z M 2□ F	70	Yrs.	Months Days	Hours M	lin.	(Month, Day, July &	3 , 193	8 Cour	MD
	Usual Residence of Decedent		10 00 7								Od Inside City Limits
'n	10a. State 10b. County Baltimo	ore	10c. City, To	own or Loc	Balti	more					0d. Inside City Limits 1 ☐ Yes 2 XNo
al Directo	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cour	ntry?
5	7311 Conley St	reet				224			US		,
ē	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin?	(Specif	y Yes or No-		ace - Americ	
7	1 Never Married 2 Married	1 TYes 2 □ N	Ю	1	☐Yes 2XINo	Specify:	26110 1110	an, oto.,	Spec		ite
d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						- 1		, ,,11	
Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give k	ent's Usual Occup ind of work done O NOT use retired	during most of v	working		16b. Kind of	Business/in	dustry
E O	Elementary/Secondary (0-12)	College (1-4or 5	+)	Bak		•			Woo	odley	Bakery
Se C	17. Father's Name (First, Middle, Last)					18. Mother's N					
0	Adam E. Simon					Netti	ie I	Jef	fers	on	
	19a. Informant's Name/Relationship (T		1	19b. Mailing	g Address (Street	and Number or	r Rural R	Route Number	, City or Tow	ın, State, Zip	Code)
	Vivian Dixon /	freind	Joh Diese		1 Conle		eet Date		more 20c. Location		
	20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ I				ition (Name of atory or other place Valley		/11/		Balt	•	
	4 ☐ Donation 5 ☐ Other (Specify, 21. Signeture of Funeral Service Licens		Dui	-	Name and Addre	on of English					
	Potoute a	Hum			Connell	3		Mace			
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. [o not ente	er the mode of dyi	ng, such as care	diac or r	espiratory arr	est,	issex	Approximate Interval Between
	Immediate Cause (Final disease or condition			Rech	iratory_	Failur	ρ.				Onset end Death
	resulting in death)	a. Due to (or as	consequen	ce of):	11111019	1011100.1					3 6673
	Sequentially list conditions,	b. Preum	onia								3 weeks
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	1 .								3 weeks
xan	that initiated events resulting in death) Last	Due to (or as		ce of):							2 VVCEKS
		d									
ledical											
an/N	23b. was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal de	ath 3	Ectopic pregnanc	CV				Date of deliv	
Physician/I	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	time of deat	h 5□	Other (specify) _					Month	Day Year
	Part II. Other significant conditions co	entributing to death but	ut not resultin	a in the un	derlying cause giv	en in Part I.		23e. Did to	bacco use co	ontribute to t	he cause of death?
Completed by		Ů			, ,			1 □ Ye	es 2 No	3 ☐ Prol	bably 4 JUnknown
ete								24a. Was a	n 24	b. Were auto	posy findings available
E E								autops perfori	med?	death?	opsy findings available impletion of cause of
Be C	25. Was case referred to medical					26. Place of	Death ((1 □ Yes Check only on	2 [4] No	1 Yes	2 No
	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 / Inpatie	nt 2 🗆 ER	/Outpatien	t 3 DOA Oth	ner: 4 🗆 Nursin	ng Home	5 🗆 Reside	ence 6 🗆 C	Other (Speci	fy)
:uo	27. Manner of Death 1. ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry 28 <i>y, Year)</i>	b. Time of Injury	28c. Inju Wor	ry at ·k?	280	d. Describe he	ow injury occ	urred	
cati	2 Accident investigation 3 Suicide 6 Could not be	00-5	- 111	f :	M 1 □	Yes 2 □ No		I I an-ti-			-1 Posts At 1
ical Certification: To	4 Homicide determined	28e. Place of Inju building, etc	iry - At home c. (Specify)	, tarm, stre	et, ractory, office		281	City or Town	treet and Nui n, State)	mber or Hun	al Route Number,
ٽ س		ysician: To the best									
<u> </u>		iner: On the basis o									

			1 - State of N	Maryland / Depa <i>Ce</i>	artment of I rtificate of			gien@ () () 9	07374
	Dhysisi	ian	Decedent's Name (First, Middle, Last)	6.	_		2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medi		Dorothea	21	nivers	>	3	5 2009	07.45 M
	Examir	ner	4a. Facility Name (If not institution, give street and number 1107 Abbotts St.	or)	Baltim			4c. County of Dea	th
	Funeral Director		213-20-1906 1DM XDF	Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day 1 / 4 / 2 1	, Year) 9. Bir C NC	thplace (State or Foreign ountry)
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the M a or 28a-f	Directo	10e. Street and Number 1107 Abbotts St.	1	10f. Zip Code 21202	2	1	0g. Citizen of What Co USA	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 ie marked other then "neturel", or items 23a or 28a-f show other treumatic event, If a Maxical Examinar must be incitilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced	s? Ø No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ ★ o	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Afr Specify Ame	e, etc. 1 Can
21215-0036	ithin 72 ho ne. nen "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	(Give	DO NOT use retire	during most of work ad)	sing	16b. Kind of Business	
	2 should be filed within 72 hours and Mental Hygiene. ie marked other then "neturel", eurnatic event, I're Medicul Exa	Be	17. Father's Name (First, Middle, Last) John E. McArthur	MC	rtician	18. Mother's Nam Sallie		Maiden Sumame)	
Maryland	nd 2 should Ith and Me 27 ie mark treumatic	2	19a. Informant's Name/Relationship (Type, Print) Sally E. Johnson/Daugh				al Route Number	; City or Town, State,	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health at Importent: If item 27 ie any injury or other treu		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)	20b. Place of Dispo	sition (Name of matory or other pla	(ce) 2 / 4 :	Date	20c. Location - City or Balt., MD	Town, State
Balti	permit. Departm Importe any inju		21. Signature of Fyneral Service Licensee,	22	2. Name and Addre	ess of Facility Hai Lair Rd,	ci P. C Balt., M	lose F.S MD 21206-	vs,PA 5105
	Physician		23a. Part 1. Ener the disease a complications that caus shock, of heart failure. List only one cause on each Immediate Cause (Final disease or condition			ng, such as cardiac			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) a Due to (or	as a consequence of):		wę co	7	3 4 6 4 6	LO STS
	cuted od	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):					
8760,	cate be executed x y physician and the burial-transit	dical Exa	resulting in death) Last Due to (or and d	as a consequence of):					
P.O. Box 6	e death certifi he attending ied for use as	Completed by Physician/Mec		2 Fetal death 3 at time of death 5	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	ivery Day Year
	quires that the signed by to all the detach	d by Pl	Part II. Other significant conditions contributing to death	0	nderlying cause gr	ven in Part I.		pacco use contribute to	the cause of death?
Vital Records,	sician: The law requir certificate has been si lirector, page 2 should	omplete	Disseder, psy	chosis			24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ita		a	25. Was case referred to medical			26. Place of Deat			24110
<u>_</u>	> .01 0	To B	examiner? 1 ☐ Yes 2 ② No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatier	nt 3□ DOA Ott	ner: 4 Nursing Ho	me 5 Reside	ence 6 Other (Spe	city)
Division of	ling After fune	atlon;	27. Manner of Death 1 X Natural 3 Accident 28a. Date of Ir (Month, I	ojury 28b. Time o Day Year) Injury	Wo	ry at rk?] Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
Divis	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined 28e. Place of building,	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (St City or Town	reet and Number or Ro n, State)	ural Route Number,
	Vo the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner	of examination and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
) .	withir To th	Me	29b. Signature and title of certifier Willelie 'Wile	doren M	29c. Licens	4 5 7 5	7 2	9d. Date signed (Mont	h. Day, Year) 5 2 00 9
			30. Name and address of person who completed cause of Mathew Mc Na	f death (Item 23a) (Type,	Print)	CYEYA	An	Be H N	5,2009
	Sta Registi			strar's Signature	land	41-			

DHMH 17 Rev 1/2001

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Experiment must be notified at once.

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Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Cer	tificate of L	Death	Reg	1.No. 2009	07376
1. Decedent's Name (First, Midd					2. Date of Death Month	Day Year	3. Time of Death
Charles Homer					3 (5 2009	435 AM
4a. Facility Name (If not institution		i		Location of Death		4c. County of Death	
FRANKLIN SQU 5. Social Security Number		ne (In vrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltim 9. Birth	place (State or Foreign
240 50 7296 Usual Residence of Decedent	1⊠ M 2□ F	74 Yrs.	Months Days	Hours Min.	Mov. 17, 19	034 North	Carolina
10a. State 10b. County	<i>y</i>	10c. City, Town or Loc	ation			1	0d. Inside City Limits
Maryland Balti	more	Esse	x				1 □Yes 2 X No
10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
1900 Grove Mano	r Dr. Apt. 2	25	2122	21		USA	
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	□Yes 2X No	Specify:			ite
15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of work	ing 16	6b. Kind of Business/In	dustry
Elementary/Secondary (0-12)	College (1-4or	5+)	oo not use retired echanic)		Automotiv	0
17. Father's Name (First, Middle,	, Last)		CCIACILE	18. Mother's Name	e (First, Middle, Ma		С
Brodous Shehan				Anna La	uder		
19a. Informant's Name/Relations	ship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Rui	ral Route Number, (City or Town, State, Zip	Code) 21221
Sharon Shehan	(Wife)				pt. 225 B	altimore,M	aryland
20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 ☐ Removal from State	20b. Place of Dispos				c. Location - City or To	
4 □ Donation 5 □ Other (5	Specify)	Bayview C				altimore,	Maryland
21. Signature of Funeral Service	Licensee	B:	ruzdzinsk 407 Old E	is of Facility Li Funera Lastern Av	l Home P. venue Ess	A. ex, Maryla	nd 21221
23a Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	d the death. Do not ente				-	Approximate Interval Between
Immediate Cause (Final disease or condition	card		mann	ade		1	Onset and Death
resulting in death)	u.	a consequence of):				AOPTA	oo minares
Sequentially list conditions	b. Dissec	Ting An	eurysm	of Th	e asce	nding 1	36 hours
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
that initiated events resulting in death) Last	c	a consequence of):	<u>-</u>				
		, ,					
	d				-		
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death 3	Cotonia presence	,		23d. Date of delive	ery
in the past 12 months? 1 ☐ Yes 2 ☐ No			Ectopic pregnancy Other (specify)			Month	Day Year
9 Unknown							
Part II. Other significant conditi	ions contributing to death b	out not resulting in the un	derlying cause give	en in Part I.		cco use contribute to the	
					I L Yes	2 No 3 Prot	Dably 413 UNKNOWN
					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
					1 Pres 2		2 🗆 No
25. Was case referred to medica examiner?	Hospital:		Othe	Ar:	h (Check only one)		
1 Yes 2 No	28a. Date of Ini	ury 28b. Time of	t 3 DOA 28c. Injury	4 Li Nursing Ho	ome 5 Residence 28d. Describe how	be 6 Other (Specification)	y)
1 ☑Natural 5 ☐ Pendi		ay, Year) Injury	Work	? /es 2 □No	200. 2000.130 1101	ngary cocarred	
3 ☐ Suicide 6 ☐ Could	not ho	jury - At home, farm, stre c. <i>(Specify)</i>	et, factory, office		28f. Location (Stre	et and Number or Rura	Il Route Number,
4 ☐ Homicide determ	building, et	с. (Бреспу)			City or Town,	State)	
	ing Physician: To the best I Examiner: On the basis of and manner st	of examination and/or inv					
29b. Signature and title of certifie	-		29c. License	number	290	. Date signed (Month,	Day, Year)
) (ill	405		RE	50000		3-6-2	009
30. Name and address of persor	who completed cause of	ath (Item 23a) (Type, F					- /
DRalex Hua	ng 9000	FRANKLIN	Square	DR	Baltima	ore MD	21237
31. Date filed (Month, Day, Year,	2. Registi	rar's Signature					
MAR 1 0 2	UUY Sendia	p. pour					

State

Registrar

			1 - State Registrar		artment of Health and rtificate of Death	Niental Hygier Reg. N	_/ 11113 11/3//
-	Physic /Medi		1. Decedent's Name (First, Middle, Last) Gloria B. Shell			2. Date of Death	Day 2009 0857 A M
	Funeral Director	ner	4a. Facility Name (If not institution, give street and numerical Social Security Number 6. Sex 217–56–9940 1 M 2 X F Usual Residence of Decedent 10b. County	7. Age (In yrs. last birthday) 57 Yrs.	4b. City, Town, or Location of Dea	8. Date of Birth	
	a-fsho	ctor	MD Baltimore	Dundalk			1 ☐ Yes 2 X No
	23a or 28	ral Director	1936 Denbury Dr.		10f. Zip Code 21222	10g. C	Citizen of What Country?
9600	Popartiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhane rust be nettilled at once.	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes . 3 ☐ Widowed 4 ※ Divorced If Yes, Give Year or Da	e tes:	Nas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Pue I □Yes 2¶ No Specify:	Specify Yes or No- tto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	giene. er than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Operator	rking	Kind of Business/Industry CTORY WORKER
yland	Mental Hy arked oth atic event	To Be (17. Father's Name (<i>First, Middle, Last)</i> Phillip W. Siejack		18. Mother's Na Mary B	me (First, Middle, Maide aumer	n Surname)
e, Mar	Health and m 27 is m			Son 1936	g Address (Street and Number or Fi Denbury Dr., Dund	ural Route Number, City dalk, MD 212	or Town, State, Zip Code) 222
Baitimore,	tment of H tant: If ite		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	Holy Rosa	ry Cemetery 03/12	2/2009 Dund	Location - City or Town, State
na Pa	Depar Impor any ir	d d	21. Signature of Funeral Service Licensee	110.192 20	Name and Address of Facility Rep 18 E. Baltimore	oc., baltilik	Funeral Home,PA ore, MD 21224
E	nysician Medical xaminer	iner	Sequentially list conditions b. Dialog	r as a consequence of):	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Batween Onset and Death
x oo/ou, certificate be executed		ledical Ex	Duè to (o)	as a consequence of):			
at the death cer	led by the attending p detached for use as	Physician/IV	in the past 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
he law requires that the death cer	igne pe c	ρ	Part II. Other significant conditions contributing to dea	th but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death? No 3 Probably 4 Unknown
The law	ate has b	e Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Physician:	this ce	5 B		patient 2 ER/Outpatient	Othori	th (Check only one) ome 5 ☐ Residence	6 ☐Other (Specify)
in g	After Uner	tion:	27. Manner of Death 28a. Date of 1 Natural 5 Pending (Month, 2 Accident investigation	Injury 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injur	
tal or Atter	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, stre , etc. <i>(Specity)</i>	12100 2310	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,)
To the Hospital or	in 24 hou he Funer ipletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and mann	is of examination and/or invi	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cause(s rred at the time, date and	s) and manner as stated. d place, and due to the cause(s)
Jo t	To 1		29b. Signature and title of certifier Workshop Signature and title of certifier	> MD	29c. License number D0067517		te signed (Month, Day, Year)
	Stat		30. Name and address of person who completed cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the cause of the complete cause of the cause of th	of death (Item 23a) (Type, P		more, MD	21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 6 Month 3 06=05 AM **Physician** Deloves Schuman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Parla Severner Severna (funce If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours 1 □ M 2 🗓 F 219-16-8640 March MD Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Linthicum with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 U.S.A. 20 Lake Front Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene.

27 is marked other than "in traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be William J. Smith Sr. Barbara E. Spiegel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Mr Robert I. Schuman/Husband 20 Lake Front Drive Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 7. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service I 22. Name and Address of Facility Singleton Funeral & Cremation 79 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) andio ressula **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) has been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ha 2 🗆 No 1 ☐ Yes 2 🗓 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation nours after death.

neral Director: At filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

DHMH 17 Rev 1/2001

DIANA NG 31. Date filed (Month, Day, Year)

CRN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29b. Signature and title of certifier

Severna Parla

29d. Date signed (Month, Day, Year)

MD 21146

03-06-2009

			For State Registrar	S	State of	Marylan		artmei <i>rtifica</i>				lental Hy	/gien Reg. N		9	07	379
			Decedent's Name (First, M.	iddle, Last)								2. Date of De	eath		Year	3. Time o	f Death
	Physicia /Medic		Kenneth G. So					1				03-02-	200	9		700	A M
	Examin	er	4a. Facility Name (If not instituted Upper Chesape				r	1 .	, Town, o Bel A	r Location A i r	of Death		4	c. County of Harf			
	Funeral	-	5. Social Security Number	6. Sex	Τ.	7. Age (In yrs.		If Unde	er 1 Year	If Unde	r 24 Hrs.	8. Date of Bi (Month, D	rth		9. Birthp	lace (State	or Foreign
	Director		218-18-5309		1 2 🗆 F	84	Yrs.	Months	Days	Hours	Min.	07-16-	192	4	Coun	MD_	
	and w		Usual Residence of Decedent 10a. State 10b. Cou			10c. Cit	y, Town or L	cation							1(Od. Inside C	City Limits
	Maryl a-f sho lied	tor	MD Har:	ford			Bel A	ir								1 ☐ Yes	2 ∑ No
	or 28e	Director	10e. Street and Number						ip Code				0	itizen of Wh	at Coun	try?	
	death with the Maryland ims 23a or 28a-f show r nust be notified at		501 New Place				- 1	1	21014					SA			
≥ 00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Inimportant: If the Marylan and Mental Hydiene. Inimportant: If the Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evancier must be notified at once.	by Funeral	11. Marital Status1 ☐ Never Married 2 X N3 ☐ Widowed 4 ☐ Divor	Married	Armed For 1 XYes If Yes, Giv Year or Da	2 □ No e	S. 13.	Was Dece If Yes, spe 1 ☐ Yes		an, Mexica Specify		ecify Yes or No Rican, etc.)	0-	14. Race Black,	White, e	itc.	
50.0	72 ho 'natur	eted	15. Dece (Specify only hig	dent's Educati	ion ompleted)		16a. Dece	kind of w	ork done	durina mo	st of work	ina	16b.	Kind of Busi	ness/Ind	lustry	
700 a	within iene. than "	Completed by	Elementary/Secondary (0-1 1 2		College (1-	4or 5+)	life.	DO NOT I	use retire	d)			ر ا	lf Emp	1037		
	filed v I Hygid other ent, if	Be Co	17. Father's Name (First, Midd	dle, Last)			Conci	acco.	-	18. Moth	er's Name	(First, Middle		<u>*</u>		- C	
() yland	uld be Mental Irked (To B	Nicholas Schr	nitt						Mar	ie Ha	arvey					
a d	2 should h and Mer is marke raumatic		19a, Informant's Name/Relati Mary Schmitt		,			0	,			al Route Numb			tate, Zip	Code)	
,	1 and Health tem 27 other to		20a. Method of Disposition	(WILE)	,	20b. F	Place of Disponentery, cre					Air, M		LO14 Location - C	ity or To	wn, State	
₩ om	Pages ient of nt: If ii		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Othe		noval from S	itate	emetery, cre 1aney			i	03-06	5-2009	Tir	nonium	n. MT)	
alt (permit. Departir Importa any Inju	Ì	21. Signature of Funeral Serv									munek					elAir
8	70 E # 9		Buan C	i. W.	ees	le	1	nc. 6	910 A	v. Ma	cPhai	LI Rd B	el A	Air, M	ID 21	1014	
	Physician		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complicat List only one o	cause on ea	ich line.	n. Do not en Brinal	CORC	/ ^		s cardiac i	10.	arrest, vrap	legia		Approxima Interval Be Onset and	tween Death
4	/Medical Examiner					or as a conseq a stusis	1	anin	no	8 51	enne	m/1	nero	static	-)>	· 1 w	eek
80	B =	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		or as a conseq		7	ue.	<i>U J</i> ,	01770	-1	City,	CEA		4 /124	Del.
1	ecute and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Leti	or as a conseq		eum.	mia	Ĺ					_/	1 000	
800	cate be executed physician and the burial-transit	dical E		l.	,	mone	,	aetar	y /	Prost	ule	Come	er		>	>1 m	onth
		ledic		a	V . V . V		7007	,						-			-
O. Box	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c.	1 Live b	come of pregna irth 2 Feta ant at time of co own	I death 3	☐ Ectopic ☐ Other (s		У				23d. Date Mont		-	Year
<u> </u>	ires that the de signed by the a d be detached		Part II. Other significant con-	ditions contrib	buting to de	ath but not res	ulting in the u	nderlying	cause giv	en in Part	I.	23e. Did	tobacco	use contrib	ute to th	e cause of	death?
eth G	w requires been sign should be	ed by	HyperKalen	ria il	400.	& hype	n cal	ams	4			10	Yes 2	2 □ No 3	☐ Prob	ably 4 🗗	Unknown
	3 0 0	Completed	Hypernutreu	rig	Dehyo	elects or	, me	tabe)ic	acid	0815	24a. Was	psy	24b. We	ere autor	sy findings	available cause of
	ate Th			recetion	1 /	Inemi.	a, 11	som	bicy	toper	49	perfo 1 □ Yes	ormed? 2 ☑ N	de 1 E	ath?]Yes	2 🗷 No	
Em Vital	Physiclan: r this certifica ral director, p	Be c	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No	-	pital: , m 6	Spationt 2 🗆	EB/Outnotic	nt 2 🗆 🗆	Oth	or:		(Check only		6 DO#==	101		
Yo	ding Phy h. After this funeral d	Certification: To	27. Manner of Death		28a. Date o	fipatient 2 of Injury h, Day, Year)	28b. Time of Injury		28c. Injui Wor	ry.at		me 5 Res 28d. Describe			· · · · ·	"	
十iois	tendir eath. or: Af the fur	catic	2 ☐ Accident inv	estigation				М	1 🗆	Yes 2]No						
m'f# Divisio	l or At after d Direct i in by	ertifi		ermined	28e. Place o buildin	of Injury - At ho ng, etc. <i>(Specit</i>	ome, farm, st	eet, factor	ry, office			28f. Location (City or To	(Street a wn, Sta	and Number te)	or Rura	Route Nun	nber,
25°	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C				best of my knousis of examinater stated.											s)
	To th To th comp	Me	29b. Signature and title of cer	tifier		00 0				se number			29d. D	ate signed (Month, l	Day, Year)	
			Kamcel	Bango	ria, 1	$(\eta, \mathcal{O},$		1	000	65 6	41		ſΥ	arch	2	20	09
C			30. Name and address of pers	son who comp	oleted cause	m.D. of death (Item 507 poistrar's Sign	n 23a) (Type,	Print)	100	2000	10,0	12	11	10 m	n '	2/21	4
7	Sta	te	31. Date filed (Mpath Par Y	19000	1 Page	oistrar's Sign	ture de	Harris .	W 34	peu	rel	1. 1	1-4	16/11	100	70/]
1	Registra		J L TIME	1 4000	1		-										

Registrar

DHMH 17 Rev 1/2001

State

10

30. Name and add

31. Date filed (Month, Day,

JONES,

MAR 1 0 2009

Year)

SLAYTON

TIMONIUM,

MD 21093

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

2300 DULANEY YALLEY

			State of Maryland / Department	artment of Health and N rtificate of Death	Mental Hygiene	009 07381
ı	Physicia	ın	1. Decedent's Name (First, Middle, Last) Lynda S. Streckfus		2. Date of Death Mayorth 04 ^{Day} 20	3. Time of Death 10:44 am
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death		inty of Death ltimore
	Funeral Director		5. Social Security Number 220-90-2249 6. Sex 1 M 2 X F 46 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) June 05, 1967	9. Birthplace (State or Foreign Country) Maryland
Ī	ryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 □Yes 2X No
	ith the Ma or 28a-f s	Director	Md. Baltimore Parkvill	10f. Zip Code 21234	10g. Citizen	of What Country?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Modeal Evan her out be neithed at	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	Race - American Indian, Black, White, etc.
-0036	hours aft tural", or	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify: dent's Usual Occupation	16h Kind o	ecity:White
21215	within 72 jiene. r than "na the Medic	Completed	(Specify only highest grade completed) (Give	ckind of work done during most of work DO NOT use retired) or Claims Adjuster	Insur	·
and	0 9	To Be C	17. Father's Name (First, Middle, Last) Paul Stavros		Terpening	name)
Mary	nd 2 shou alth and M 27 is mar r traumat			ng Address <i>(Street and Number or Rui</i> .5 Quentin Ave. Pa		
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev	1		osition (Name of matory or other place) Service Co. 3-10		on - City or Town, State
Balti	permit. Departm Importa any Inju			2. Name and Address of Facility Fu RUCK TOWSON Fu 1050 York Rd.	neral Home, I	nc. 1204
100	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	/// C C II		Jest
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events			
8760,	flicate be executed g physician and is the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d.			
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)	23d.	Date of delivery Month Day Year
ds, P.	ires that t signed by d be detac	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use c	contribute to the cause of death?
Records,	The law requir te has been s age 2 should l	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □ No	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
f Vital	Physiclan: The la	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	I Other	th (Check only one)	14 4 4 4 4 4
Division of Vital	Attending Ph death. ctor: After th y the funeral	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) Injury		28d. Describe how injury oc	
Divis	or / Oire	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Nu City or Town, State)	umber or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date and pla	ce, and due to the cause(s)
	o o with	2	29b. Signature and title of certifier Mothy fully	29c. License number 25205 Print) Print) Ba	Mu-7	gned (Month, Day, Year)
	b			Print) St. Bd	lformed 21	205
	Sta Registr		31. Date filed (Month, Day, Year) 32. Repatrar's Signature 33. Date filed (Month, Day, Year)	back		

		For State	State of	Marylan	d / Depa	artment of F	lealth Death	and Me			2009	07	382
		Registrar 1. Decedent's Name (First, Middle, Las	st)						. Date of Dea	Reg. No.		3. Time o	of Death
Physicia			rota						Month March	Day 7	2009		5 P ^M
/Medic Examin		4a. Facility Name (If not institution, give		ber)		4b. City, Town, or	r Location		'lat CII	4c.	County of Dea		<i>J</i> <u>F</u>
Examini	CI	Keswick Multi-C	Care			Balti	more	City					
Funeral		Social Security Number 6. S		. Age (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. 8	. Date of Birt (Month, Da	th v Year)	9. Bir	thplace (State	or Foreign
Director		350-10-1052	□ M 2]K] F	83	Yrs.	WOULTS Days	Tiouis	I	December	26 1		inois	
pu »		Usual Residence of Decedent 10a. State 10b. County		10a Cita	y, Town or Lo	ocation						10d. Inside 0	ity Limite
aryla shov	5	Toa. State Tob. County				Callon							2 No
he M	Director	Maryland Baltimo	re]	Cowson	10f. Zip Code				10a Citi	zen of What Co		
2 should be filed within 72 hours after death with the Maryland a and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Madeal Evandra must be notified at		205 E. Joppa Ro	ad, Uni	1006		21286					.S.A.	ounitry :	
death	Funeral	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of H	lispanic O	rigin? (Speci	fy Yes or No	- 1	14. Race - Amo		
or ite	교	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2	▼ No		1 ☐ Yes 2X No	Specify		Jan, etc.)		Black, Whit		
ours iral";	d by	3 Widowed 4 □ Divorced	Year or Dat	es:							, N	hite	
72 h	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual Occup kind of work done	durina mo:	st of working		16b. Kir	nd of Business	Industry	
within than than	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)		DO NOT use retired Maker	1)				Own Hom	ie	
Hygir ther int,		17. Father's Name (First, Middle, Last)					18. Moth	ner's Name (F	First, Middle,				
d be antal	o Be	Harry Dunn					Мо	rgaret	- Milr	037			
mark	ဥ	19a. Informant's Name/Relationship (Tvpe. Print)		19b. Maili	ng Address (Street					Town, State,	Zip Code)	
INICA Ind 2 s Inth au 27 is r trau		Stephanie I. Brat		hter	10739	Lakespr	ing L	lav Co	ckove	v:114	a Mary	land (21030
f Hear other		20a. Method of Disposition		20b. P	Place of Dispo	osition (Name of	TIIS W	Dat		20c. Lo	cation - City or	Town, State	1000
Pages ento		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	Removal from St	ate Dul	aney	osition (Name of matery or other place Valley	;e)	03-12-	-2009	Time	onium,	Marvlar	nd
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Health and Hygiene. Department of Health and Health an		21. Signature of Funeral Service Licer		Men	orial ₂	Gardens 2. Name and Addre	ss of Facil	lity Ruc	k Tow	son l	Funeral 204	-	
402.64		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that car	used the death		1050 York ter the mode of dyir			_		204	Approxima Interval Be	te
Physician		Immediate Cause (Final disease or condition	Lu		ncer							Onset and	Death
/Medical Examiner		resulting in death)	a	ras a consequ									
	e	Sequentially list conditions,	b	r as a consequ	uence of):								
iicate be executed physician and s the burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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cate be executed physician and the burial-transit	dical	•	d										
rtifica ng ph as th	Med	IF FEMALE:											
th ce	sician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregna rth 2□ Feta		☐ Ectopic pregnanc	;y			2	23d. Date of de Month	livery Day	Year
the a	/sici	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unkno	ant at time of d wn	death 5	Other (specify) _					WOTET	Duy	, cai
hat the	Phy	Part II. Other significant conditions of	ontributing to dea	ith but not resi	ulting in the u	ınderlying cause giv	en in Part	1	23e. Did t	obacco u	se contribute t	o the cause of	death?
Attending Physician: The law requires that the distribution of the distribution of the farenth is certificate has been signed by the by the funeral director, page 2 should be detached	d by		g		g	,			1 🗆 '	res 2	⊵ √No 3 □ P	robably 4 🗌	Unknown
v requestions	ete								24a. Was	an	24h Mere a	utopsy findings	available
he lave has ige 2	Completed								autor perfo	osy rmęd?	prior to death?	completion of	cause of
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rsicia s cert	o Be	examiner?	Hospital:	patient 2 🗆	EB/Outpatie	nt 3 DOA Oth		e of Death (S ☐ Other (Spe	20(64)	
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ath. T: Affe	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	,	, Day, Year)	Injury		k? Yes 2. []No					
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		I foron Sho	& m	0		0006	1199	7		Ma	1. 9.	2009	
12		30. Name and address of person who	completed cause	of death (Item	m 23a) (Type,	Print)	h (1 200	3 7			0,000	-/
		31. Date filed (Month, Day, Year)	M 1). 6)	61 No	1774 W	narles >1	, 10,	te 10	1 106	104	141)	2120	
Sta Registr		30. Name and address of person who In Solution (Month, Day, Year)	2009	- Constant	1. 1	bark							
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		Please	Type or Print in						ble.	
		For State Registrar	State of Maryl		oartment of F e <i>rtificate of</i>		Mental Hy	giene Reg. No. 20	09	07383
		Hegistrar Decedent's Name (First, Middle, Las	t) ; C				2. Date of De	eath	Year -	3. Time of Death
Physicia /Medic		Thomas L	ester S			- Landing & David	Febru	10 mg d /)	2009	9:40 PM
Examin	er	4a. Facility Name (If not institution, give Battimore Repabil	itation Exlen	ded Ca	we	r Location of Deat imore	n	4c. County	of Death	
Funeral		5. Social Security Number 6. So		yrs. last birthda 86 Yrs.	17711 1 1 1 1	If Under 24 Hrs Hours Min.	(Month, D	rth ay, Year)	Coun	* /
Director		215–18–5464 Usual Residence of Decedent	·-				Jan 16,	1923	Mary.	land
show	7	10a. State 10b. County	unk 10c.	City, Town or Farm					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	recto	VA 10e. Street and Number		rarıı	10f. Zip Code			10g. Citizen of	What Count	41
23a or	Funeral Director	P.O. Box 368			22	460		1	JSA	
items	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 14 Yes 2 □ No	n U.S. 13	 Was Decedent of F If Yes, specify Cub 	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		ce - America ck, White, e	
ours aff	þ	3 ☑ Widowed 4 □ Divorced		0-45	1 □Yes 2 ሺ No	Specify:		Specit	y: whi	te
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should nd Mei marke imatic	ပ	Luther Scott 19a. Informant's Name/Relationship (7)	Type. Print)	19b. Ma	iling Address (Street		s Lesten ural Route Numb		State, Zip	Code)
and 2 ; ealth a n 27 is ier trau		Ronald Gerhart/br			3 Buchana					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemoval from State	b. Place of Dis cemetery, c	position (Name of rematory or other pla	ce)	Date	20c. Location	- City or To	wn, State
permit. Pa Departmei Important any Injury once.		4 ☑ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen Ronal d S	7/		22. Name and Addre	ess of Facility	1 (55 **		-	
Der any		23a. Part . Enter the disease, or comp			State Anat Saltimore,	-			ore S	treet ————
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n: The ficate h rr, page		25. Was case referred to nedical				00 71 (7	1 ☐ Yes	órmed? 2 DNo	death? 1 ☐ Yes	2 1 No
nysicia iis cert	lo Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ient 3 □ DOA Oth	hor:	ath <i>(Check only</i> Home 5 ☐ Res	idence 6 Ot	ner (Specify	Rehab
ling Pt. After th uneral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time Injur	y Woi		28d. Describe	how injury occur	red	
Attend r death cctor: by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home, farm,]Yes 2□No		Street and Num	ber or Rura	I Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the law that the funeral director.	ledical		ysician: To the best of my niner: On the basis of examiner and manner stated.							
To the within To the comple	Med	29b. Signature and title of certifier		taar h	29c. Licens	se number		29d. Date signe	ed (Month, I	Day, Year)
		Heorge	i. Wills	DV I	D pq	1360		tebru	my 2	1, 2001
		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	Print) Lock	n Roven	Boule	vard, 4	SOH	21218
Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	and			ē		
Registr	ar	MAR 1 0 20	14 Cleans	p. 19						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 07384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea 09 **Physician** 4:30 1 March ames nitr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Kandalistawn enesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/28/1926 Birthplace (State or Foreign Country)
 Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 M 2 □ F 238-26-7662 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 No Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9101 Liberty Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y Yes 2 No 19 If Yes, Give Year or Dates: 1945 ^{2□ No}1943-1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: African-American Completed by 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Joseph Banks Elementary/Secondary (0-12) College (1-4or 5+) Clerk 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unk. Be Mary Hynes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer S. Smith / Daughter 17 Cinnomin Circle, Apt. 3C Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National 3/11/2009 Laurel, Maryland 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Maryland National 9200 Liberty Road Randallstown, Maryland 21133 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spiration Physician preumonia Weeks disease or condition resulting in death) /Medical Due to (or is a consequence of): Examiner yeurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 ☑ No 1 ☐ Yes 3 Probably 4 ☐ Unknown phagi 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No -allure 24a. Was an was ...
autopsy
performed?
Yes 2 MNo page 2 s After this certificate funeral director, pag Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death, 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2. To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpreted cause of death (Item 23a) (Type, Print) 3+1 30. Name and address of person who com Libert 31. Date filed (Month, Day, Year) Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 1TEM 5 PER FH, G889, 03/12/09DHB
State of Maryland / Department of Health and Mental Hygiene 0 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:37 PM Thorn ton -croy) 2009 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Baltimore UMMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 478-1 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Wash. Months 1**₩** M 2□ F Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show the Medical Examiner must be notified at Bal 1 es 2 No **Funeral Director** TO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itama 23e any Injury or other traumatic event, the Manten 2122 . Was Decedent Ever in U.S. Armed Forces? 1 154 Yes 2 ☐ No If Yes, Give Year or Dates: 1952 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: Black 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lerk Governmen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be /hornton ည STON lames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) alto. 20b. Place of Disposition (Name of cemetery, cremator) d 2122 MOTINTON 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee and Address Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute myocardial **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. within 24 hours after death. To the Funeral Director: After this certificete hes been signs completely filled in by the funeral director, page 2 should be 3 Probably 4 Wonknown 1 Tyes 2 No Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 N6 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year, 29b. Signature and title of ceptifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RKER Baltimon, MD 22 St. 31. Date filed (Manth Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07386 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month RCHPay Z 2 2 1 2 1 9 **Physician** 12:30FM Miriam E. Turner-Fitzsimmons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balt Examiner Saint Joseph Medical imore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of Month, Day, Year) 7. February 4,1922 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2 F 87 213-16-5435 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Fallston Md. Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 USA 3107 Fallston Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it. Medical Evaminations. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Bethlehem Steel Mill Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Hagen Theodore E. Leib ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nottingham, Md. 21236 4007 Kalston Rd. Son Leonard Turner 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Timonium, Md. 3-11-2009 Dulaney Valley 22. Name and Address of Facility 21. Signature of Funeral Service Liophsee Schimunek Funeral HOme 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknowh 23d. Date of delivery 3 Ectopic pregnancy for Day Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 URINARY TRACT INFECTION 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 28a. Date of Injury 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day, Year) 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

completely filled in by the funeral 24 hours a within 2 To the I

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

RICHARD ...

withicum

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

- D 31826

7601 OSLER DRIVE TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 07387 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year PAULETTE FRANCES TANENBAUM MARCH 8 /Medical 2009 9:07 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 3704 Prospect Road Street Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 3, **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours Min. Year 141-22-9288 **Director** 79 1930 France Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it with the motified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ∏Yes 2 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3704 Prospect Road USA 21154 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob David Townsend မ Bertha (unk) Simonnet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah A. Fedele / Daughter 3704 Prospect Rd., Street, MD 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 3-11-09 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Steller 50 W. Broadway, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed A hours after death.

Authorisal Director: After this certificate has been signed by the attending physician and stely filled in by the furnerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

completely

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PHELEP NEVATPL

DHMH 17 Rev 1/2001

602 S. ATWOOD ROAD

D0028472

29d. Date signed (Month, Day, Year)

BRLAGR

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHYSICIAN

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a,26,27 per dr., 9889,03/10/09dhb
Reg. No. 2 Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Day Year Physician 09 John C. Thomas 21 1057 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 19, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Months 61 1947 215-46-5469 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show MD **Allegany** 1 ☐ Yes 2√∑ No Frostburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 Honeysuckle Lane #305 21532 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Thomas ၉ <u>Virginia Lenore Toft</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Thomas/brother 129 Riverside Road Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock cheart failure. List only one cause on each line. Immediate Cause (Final rdiac 15cHmic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and it be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? To the Funeral Director: After this certific completely filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed a

517 OIDTOWN ROAD.

uee of death (Item 23a) (Type, Print)

RANTITHAN

		For State Registrar	State of Maryla		Pertificate of			leg. No.	009	07389
Physicia	an	1. Decedent's Name (First, Middle, La	,				Date of Dea Month	th Day	Year	3. Time of Death
/Medic		SAmuel J.					MArch	6	2009	10:00AM
Examin	er	4a. Facility Name (If not institution, given Bel Air Heal			4b. City, Town, or Bel	r Location of Death Air		1	unty of Death arford	
Funeral Director		5. Social Security Number 6. S 206-12-8495	Sex 7. Age (In)	yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 9	(Year)	Coun	lace (State or Foreign try) PA
and bw		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town o	r Location				11	0d. Inside City Limits
e Mary la-f shu tifled a	ctor	MD Balti	.more		Middle Ri	ver				1 ☐ Yes 2 🛣 No
th with the 23a or 28 ist be no	al Dire	10e. Street and Number 502 Middle F	River Road		10f. Zip Code 2122	21		10g. Citizer US	n of What Coun A	try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, I'm. Medical Examiner must be notified at Once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🎛 No		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, e pecify: Wh	
"natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(0	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of work	ing	16b. Kind	of Business/Inc	dustry
yithir giene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	aneOperat	,		Betl	h Stee	1
e filectal Hyg	Be C	17. Father's Name (First, Middle, Last	<i>'</i>			18. Mother's Nam		Maiden Su	rname)	
ould b	인	Salvatore Ur				Emili				
od 2 sh lith and 27 is m		19a. Informant's Name/Relationship Maryann Falli		1	lailing Address <i>(Str</i> ee <i>t</i>					,
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permit. F Departm Importar any injui		21. Signature of Funeral Service Lice			22. Name and Addre	ss of Facility 30	0 Mace	Ave	. Balt	o. MD
9 9 E 8 9		Vatruelo R	Oliny		Connell	y Funer	al Home	e of		21221
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	mal	cell c		or respiratory arı	rest,	7-	Approximate Interval Between Onset and Death
rificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const. C. Due to (or as a const.) d	. ,						mus-yew
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending portine funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the state of the funeral director.	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		230	d. Date of delive	ery Day Year
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equire sen sig	ted t	CA	D				1 🗆 Y	es 2 n	No 3□ Prob	ably 4 Unknown
The law rate has be	Completed	HT	N				24a. Was a autops perfor 1 ∐Yes	sy	24b. Were autop prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
cian: ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of Deat		,		
Physical this call dire	2	1 Yes 2 No	Hospital: 1 Inpatient 2			4 Nursing Ho	ome 5 Resid			v)
tending I eath. or: After the funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		r) 28b. Tim	iry Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury o	ccurred	
tal or Att s after do al Direct ed in by 1	Certific	3 □ Suicide 6 □ Could not b 4 □ Homicide determined			, street, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rura	l Route Number,
ne Hospii n 24 hour ne Funeri pletely fill	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, on and/	death occurred at the ti or investigation, in my o	me, date and place opinion, death occur	and due to the or	cause(s) ar late and pla	nd manner as s ace, and due to	tated. the cause(s)
De la	Σ	29b. Signature and title of certifier	completed cause of death (29c. Licens	e number 6545		3/s	igned (Month, I	Day, Year)
		30. Name and address of person who	completed cause of death ((Item 23a) (Ty	pe, Print) A ys ST =	4/02/	BEL	AI	R, MS	2 2 10/4
Sta		31. Date filed (Month, Day, Year)	32. Hegistrars Si	ignature		-				
Registr		MAR 1 0	2009 Genera	1.	parke					

State of Maryland / Department of Health and Mental Hygiene 2009

07389

Verna, UPTON

			Please 1 - State Registrar		aryland / D	c Indelible Ink Department of I Certificate of	Health and	Mental Hyg	_	07390
П	Physici /Medio		1. Decedent's Name (First, Middle, L Verna	ast)		Upton		2. Date of Dear	Day 2009	3. Time of Death
	Examin Funeral Director	er	216-20-4301	tington in	e (In yrs. last birt	CENTER		WRUB	4c. County of Dea ANKE 9. Bir (County) 1927	th ARUNE VEL thplace (State or Foreign ountry) MD
	e Maryland a-f show inc.d.et	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	undel	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 111 3rd Avenue	SW		10f. Zip Code 21061			0g. Citizen of What Co	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Exercitizational be refined at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. No	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whit Specify: W	e, etc.
21215-0036	vithin 72 ho ene. Ihan "natu e Medical	Completed by	15. Decedent's t (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or t	<u></u>	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wor ed)	rking	16b. Kind of Business	/Industry
Maryland 2	uld be filed v Mental Hygie rked other i tic event, in	To Be Co	17. Father's Name (First, Middle, Las Albert S. Muhl	ot)	n	omemaker		me (First, Middle, I G. McKer	·	
Mary	ind 2 shor alth and h 27 is ma er trauma		19a. Informant's Name/Relationship Mr. Vincent Seri			Mailing Address (Stree 8 Riverside				Zip Code)
Baltimore,	Pages 1 anent of He ant; If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		I	Disposition (Name of c, crematory or other plant Park Ceme		ch 9,	20c. Location - City or Baltimore,	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Lice		K01357	22. Name and Addre	ess of Facility Sin		uneral & C Glen Burnie	remation , MD 21061
1.6	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition	mplications that caused y one cause on each li	d the death. Do n ne.	ot enter the mode of dy	ing, such as cardia	c or respiratory arr		Approximate Interval Between Onset and Death
	/Medical Examiner	L	resulting in death)	b. Dye to (or as	a consequence of		Acus FAILUR	€		
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of Vital Records,	sician: The law r s certificate has be irector, page 2 sh	Completed	25. Was case referred to medical	···-					ned?/ death? 2 ☑No 1 ☐ Yes	utopsy findings available completion of cause of
of Vii	hysicia this cert al directo	To Be	examiner? 1 □ Yes 2 ☑ No			patierit 3 🗆 DOA	her: 4 🔲 Nursing H		ence 6 Other (Spe	ecify)
Division o	Attending Phys death. ctor: After this y the funeral dir	ation:	27. Manner of Death 1		ury 28b. T iy, Ye <i>ar)</i> Ir	jury Wo	iry at rk?]Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	ury - At home, far c. <i>(Specify)</i>	m, street, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	the Hospital hin 24 hours a the Funeral I upletely filled	Medical	29a. Certifier 1	Physician: To the best aminer: On the basis of and manner st	of examination and	death occurred at the t	time, date and place opinion, death occu	e, and due to the c urred at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To t To t	Ž	29b. Signator and title of certifier	7 N	w	29c. Licen			9d. Date signed (Mont	
	2 /		30 and address of person to	completed squse of d	Hocz	Type, Print) du	rive G	Len B	urnie '	6.2009 mo 20161
	Sta Registr	ar	31. Date filed (Month, Day, Year)	32. Registr	ar's signatu					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Beverly Μ. Upton MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-20-1926 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. 213-28-0119 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Glen Burnie 1 □Yes X□No MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 3rd Avenue SW U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Acmed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Insurance Salesman Insurance permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any ligiury or other traumatic event, the answer Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward L. Upton Ida 0. P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 858 Riverside Drive Pasadena, Maryland 21122 Mr. Vincent Serio, Jr. /Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services, P.A. 1 2nd Ave SW Glen Burnie, MD21061 1201357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner oronam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknowr cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The certificate 2 No 2 🗆 No Division of Vital 1 □ Yes 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1∐Yes 2**X**No 1 Inpatient ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

2+1

State

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Jear)

MAR 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

HOSPITAL DRIVE GLEN BURNIE, MO 21061

			For Amend] - State Registrar	tem 26 per	verb	, g88 Cert	ificate of	teaim and 09dhb Death	Mental Hy	/greme Reg. No	2009	0/392
	Physicia	an	1. Decedent's Name (First, Middle, La Maria Del Transi	,	.ez				2. Date of D Month Februar		2009 Year	3. Time of Death
**	/Medic Examin		4a. Facility Name (If not institution, gi	•			4b. City, Town, or	r Location of Dea			. County of Death	n
-egg*		•	Laurel Regional				aurel, N	Maryland		. 1	ince Ge	0
	Funeral Director		214-51-0312	Sex 7. Age 1 □ M 2 🙀 F	e (In yrs. las 5	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi				nplace (State or Foreign untry) duras
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ation					10d. Inside City Limits
	Mary I-f sh	tor	MD Prince	Georges	Laur	e1						Mg∑Yes 2 No
	h with the 23a or 28a	Funeral Director	10e. Street and Number 41o Maint Street	Unit# 7			10f. Zip Code 20707				tizen of What Col luras	untry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Merical Examinational Language.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 The If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba		(Specify Yes or Norto Rican, etc.) ndurian	0-	14. Race - Amer Black, White Specify:His	, etc.
21215-0036	vithin 72 h ne. han "natu u Medeal	Completed by	15. Decedent's Elementary (Secondary (0-12)	ducation ade completed) College (1-4or 5	+)	(Give k life. Di	ent's Usual Occup ind of work done O NOT use retired	durina most of w	orking		Kind of Business/I	ndustry
d 2	filled w Hygie ther t		17. Father's Name (First, Middle, Las			Home n	naker	18. Mother's N	ame (First, Middl		f home Surname)	
<u>a</u>	ld be lental ked o ic eve	To Be	Gilberto Viera					Eudomi	lia Fern	nan		
ary	shou and N s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing	Address (Street	and Number or	Rural Route Num	ber, City	or Town, State, Z	Tip Code)
ž,	and 2 salth a 27 is er tra		Rafael Omar Velas	squez (Son)			ars Kno		Hanover	, MD	21076	
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai <u>once.</u>		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 0 4 □ Donation 5 □ Other (Spec		20b. Pla cer Ceme	ce of Dispos netery, cremi tery: Amon	ition (Name of atory or other place Jardines Eterno	s de Marc	Date :h/14/09		ocation - City or 1.	rown, State , Hondurasd
Balti	permit. Departn Importa any inju		21. Signatur, o Funeral S o j	O. Hou	1	22.	Name and Addre	ess of Facility Sa	nta Cruz	z Fur		Latinos, Inc
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	I the death. ne.	Do not ente	r the mode of dyir	ng, such as card	ac or respiratory	arrest,		Approximate Interval Between
-	Physician	1	Immediate Cause (Final disease or condition	SEPSIS	SYNDR	OME						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as								
	Lamino	<u>.</u>	Sequentially list conditions,	b. SEPTIC Due to for as								
	nsit	mine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	RESPIRA		-	RE					
Ć,	execting and and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as								
68760,	tificate be executed ig physician and as the burial-transit	ledical		_d								
	ertifica ing ph e as th	Med	IF FEMALE:					0-17-1				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal c	death 3 🗌	Ectopic pregnand Other (specify) _	cy			23d. Date of deli Month	ivery Day Year
ds, P.	ruires that the de n signed by the a lid be detached t	þ	Part II. Other significant conditions	contributing to death b	ut not result	ting in the un	derlying cause giv	en in Part I.				the cause of death?
Records,	e faw requir has been s e 2 should	Completed							24a. Wa	s an opsy formed?	prior to o	topsy findings available completion of cause of
a F	r: The icate r, pag			1					1 □ Yes	2 N	death? o 1 □ Yes	2 □ No
Vit	siciar certif rectol	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: X		70.0	3□ DOA Oth		eath (Check only			. Hospital I
of	Physer this eral di	7: To	27. Manner of Death	28a. Date of Inju		R/Outpatient 28b. Time of	28c. Inju	ry at	28d. Describe		6 ☐ Other (Specury occurred	city)
ion	nding ath. r: Affe e fune	ation	1 Natural 5 □ Pending 2 Accident investigati		y, Year)	Injury	M 1 🗆	rk?]Yes 2. □No				
Division of Vital	al or Atte s after des Il Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	20e. Place of Inj	ury - At hom c. (Specify)	ne, farm, stre	et, factory, office		28f. Location City or To	(Street a	nd Number or Ru te)	iral Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) Certifying F	hysician: To the best miner: On the basis of and manner st	of examination	rledge, death on and/or inv	occurred at the ti estigation, in my	ime, date and pla opinion, death o	ace, and due to the courred at the time	e cause(s) and manner as nd place, and due	s stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c. Licens		(-	29d. D	ate signed (Monti	h, Day, Year)
			- m L	loer			Dog	0129	65	Mar	ch 2, 20	09
			30. Name and address of person wh					tal Law	al MD			
	Sta	ite	Zorayda Lee LLac 31. Date filed (Month, Day, Year)	32. R	er's Signatu	ire	al Hospi	car Laul	el MD			
	′ Regist		MAR 1 0	2009	m :	1. 1	exter					

State of Maryland / Department of Health and Mental Hygiene 009

					Cei	tificate of	Death		Reg. No.		
	Dlavei	0.5	1. Decedent's Name (First, Middle, La					2. Date of Do	eath Day	Year	3. Time of Death
	Physic /Medi		Carroll	VanNess		MATERIAL S		Month	26 2	1009	12:00AV
A. S. Sales	Exami		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or L	ocation of Dea			re County
	Funeral			Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D	rth ay, Year)	9. Birthpl	ace (State or Foreign
	Director		213-42-7692	1∑M 2□F	66 Yrs.	Working Days		July 8	, 1942	Mary	Lánd
	p v		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				140	Od. Inside City Limits
	anyla	2									1 ☐ Yes 2√∑No
	Pe M	Director		Le	Luthervi						
	th with t	ai Dir	10e. Street and Number 210 Melanchton	Avenue		10f. Zip Code	21093		10g. Citizen of US		try?
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U,S. 13. \	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ban, Mexicen, Puerto	pecify Yes or No Rican, etc.)	o- 14. Rad Bla	e - America ck, White, e	
020	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23a or 28a-f ahow ent, the Medical Examiner must be notified at	ē	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		∐Yes 2∭X No			1	v: whi	
Ϋ́	72 h natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	lent's Usual Occu kind of work done	during most of work	king	16b. Kind of B	usiness/Ind	lustry
<u>7</u>	ithin	igh	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retin	9d)				
2	ygier ygier it, fr	S	12	2	comp	uter ana	T -		telepho		mpany
Ē	d off	Be	17. Father's Name (First, Middle, Last				18. Mother's Nam	•	, Maiden Suman	ne)	
$\frac{1}{2}$	should be and Mental and Mental sumarked or numatic even	ဥ	Carroll Van Ness				Helen			-	
, Mar	and 2 sh ealth and 127 ls m er trsum		19a. Informant's Name/Relationship Johnna M. Van Ne				tand Number or Ru ton Avenue				Code) 1093
Ĕ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Expiratric results be rutified at once.	#	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Speci	Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location -	City or Tov	wn, State
Balti	permit. F Departme Importan any injur	- Property	21. Signature of Juneral Since Lice Ronal S.	Wade Virect		Name and Addr ate Anal	ess of Facility LOMY Board		. Baltim	ore S	treet
			23a. Part1. Enter the disease or conshock, or heart failure. List only	iplications that caused the c	feath. Do not ente	er the mode of dy	ing, such as cardiac		rrest,		Approximate
	Physician		shock, or heart failure. List only	one cause on each line.							Interval Between Onset and Death
Jan .	/Medical		Immediate Cause (Final	2015	2/200	. Elle	weaths	de	60/1/2	1	
	Examiner		disease or condition resulting in death)	a. Dual			,	/	/		
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c,	certificate be executed nding physician end use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due t	o (or as a conseq	uence of):					.,
9/	sicis sicis	cal	triat iriitiateu events	c. Due to	o (or as a conseq	ience of):					
	certificat nding phy use as th	n/Medical	resulting in death) Last	d	(0.000)				\$**B.		
Ď	death atter	Physician	Part II. Other significant conditions of	contributing to death but not	regulting in the ur	darhina agusa a	ives in Bart I	22h Did	tohoooo ugo oo	ntriburto to	the causa of death?
O.	the oy the seche	hys	Tartii. Other significant conditions	onthibuting to death but not	resulting in the di	idenying cadse gi	iveri il Faiti.		Yas 2□ No		
- ·	that hed to	by P						1	145 2 140	3 - 100	abiy 4 E dikilomii
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death within 24 hours effect death. To the Funeral Diractor: After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be deteched for	Completed b	AND THE RES					24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to apletion of cause eath?
æ	e la e has ige 2	Ĕ						10	Yes 2☑No		
ā	n: Tr ficate or, pa	Ö	25. Was case referred to medical				00 80 (8			'	Yes 2□ No
5	sicial certi	o Be	examiner?	Hospital:		Ot	26. Place of Deat				MIE
ö	Phys rald	- T	27. Manner of Death	4	2 ER/Outpatien 28b. Time of	30 DOA	4 Li Nursing Ho		dence 6 10th how injury occur)
	Jing After fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) Injury	28c. Inju Wo M 1	rk? Tyes 2 □ No	200. 000000	now many occur		
2	ttendi death ctor: A	cal	3 Suicide 6 Could not b	De Diana of Inium. A	t home form str			28f Location /	Street and Numb	er or Purel	Poute Number
<u> </u>	5 # 5 E	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	et, ractory, office		City or To	wn, State)	er or ribiar	rioute rainber,
	To the Hospital or A within 24 hours efter To the Funeral Dirac completely filled in b	edical Co	(Check only 2 Madical Exar	nysician: To the best of my l ninar: On the basis of exam	knowledge, death ination and/or inv	occurred at the ti	ime, date and place, opinion, death occur	and due to the	cause(s) and ma	inner as sta	ated. the cause(s)
	the the mple	Med	one)	and manner stated.		200 Lican	se number		20d Data sizes	d /Month 5	lav Vaari
	다 폴 다 S		29b. Signature and title of certifier	- 10		_		1	29d. Date signe	u (IVIORIII), L	vay, roat/
			1332	N		11	080216		726/6	4	
			30. Name and address of person who	completed cause of death (5 N.	/ Mark	s St. PA	2 20	i fact	3, No	(ZPOY
	Sta Registr		31. Date filed (Month, Day, Year) WAR 1 0 2	32. Registrar's Si	gnature.	ale	/		/		
					- 0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 15 A M 500 200 /Medical institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death HOS Altimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**⊠**M 2□ F Months Director December 24 1937 South Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Evaminar must be notified at Director SAIHIMORE 1 XYes 2 □ No MARYlAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Ellow Wood AUR 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 28 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". HMERICAN Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Construction other 17. Father's Name (First, Middle, Last) ss 1 and 2 should be filk of Health and Mental Histem 27 is marked oth Be ဂ MIGE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eutaw Wilson BAltimore, MARYLAND 21201 Street-Baltimore, permit. Pages 1 a
Department of Hei
Important: If Item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cempetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville MARYLAND 14,2009 4 □ Donation 5 □ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service License Service FUNERAL BAItimore, MARGIAND 2229 Street OS W. FRANKIN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of its consequence of Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and Due to (or as a consequence of): death certificate be Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 1 ☐Yes 2 ☐ No 5 Other (specify) signed by the The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? Yes 2 No certificate Division of Vital 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the Funeral Director. After this certification has the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) /2 1 No Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 MOther (Specify) 40 goice Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

h. KNOX

Devid

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wihake

32. Registrar's Signature

0

0

2

Scott

Ave

29c. License number

Delto. MD 21210-1303

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year BETSY SHARKEY WOLF /Medical MARCH 2009 4:44 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 27 KEMPER AVE. WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🙀 F 217-22-2667 Yrs Director 85 10/10/1923 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director MD CARROLL 1X Yes 2 □ No WESTMINSTER the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 27 KEMPER AVE 21157 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1∐Yes 2∭XNo Specify: þ Specify: WHITE 3 X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) OWNER 12 RESTAURANT marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 Is marked o any Injury or other traumatic eve once. STANLEY JAMES SHARKEY HELEN HARITOS ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHA L. MARTIN -DAUGHTER 27 KEMPER AVE., WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State COUNTY CREMATION 3/9/09 4 □ Donation 5 □ Other (Specify) SYKESVILLE, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. ST., WESTMINSTER, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) orard /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nuac or Attending Physician: The law requires that the death certificate be executed Examin burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🔲 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? ş 1∐Yes 2∭XNo Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy certificate Division of Vital 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home & Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical o the Ho within 27 To th (Check only one) 29b. Signature and title of certifier 29c. License number d address of person who completed cause of death (Item 23a) (Type, Print) 0 mm State Registrar

DHMH 17 Rev 1/2001

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Physician /Medical Examiner pnuial-transit	Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a.y. teaching to have been cause. Enter Underlying Cause (Disease or injury that initiated events			7 T	uence of):	Infecti	on wit	4 Sep	513		Interval Between Onset and Death
leath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Ex	resulting in death) Last IF FEMALE: 23b. Was decedent pregnan	d	Due to (or as						234 [Date of delive	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Olo15 AM Weigano Lee 1arch 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital
5. Social Security Number 6. Sex 7. Age Washington

9. Birthplace (State or Foreign Country) Hagerstown f Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept 2, **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 76 220-26-5561 Director 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 7.7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the "editer Event in strong to conflict a Director MD Washington 1 ☐ Yes 2√ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 Michigan Avenue 21740 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 antique dealer collectibles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Reeder ൧ Myree Virginia Shank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Sandy Zeger/daughter 1121 Hamilton Blvd Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of cuneral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** seudo mem brancus disease or condition resulting in death) 10 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown à cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown aw nro 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy The perform ormed? 2 K No 1 □Yes 1 ☐ Yes 2 ☐ No or Attending Physician: After this certification, property of the sector, property of the sector 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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		1	for State Registrar	State of Ma	i yianc		tificate of			eg. No.	07398
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	Funeral Director		5. Social Security Number 6. Sr 578-22-2866	ex 7. Age □M 2∏X F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 25	Year) 9. Birt Co 1923 Was	thplace (State or Foreign buntry) hington, D.C
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<u> X</u>	should by and Menta s marked umatic e	To E	Harvey Huddleson					Daisy	Cornell		
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Baltimore, Maryland	Pages 1 and the sent of He sent of He sent of He sent of the sent of the sent or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Gat	$\overset{\scriptscriptstyle{metery}}{\circ} \overset{\scriptscriptstyle{crem}}{H}$	ition (Name of atory or other place eaven	Marcl 200	h 11, \mid $_{ extsf{c}}$	Silver Spri	Town, State
Balti	permit. Pages Department of Important; If it any Injury or once.		21. Signature of Funeral S. vice Licens			emeter Ro	Name and Addre	Pumphrey	Funeral	Home/Fethe	esda-Chevy
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. Box	death ce e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	! ☐ Fetal (death 3 🗌	Ectopic pregnand Other (specify) _	у		23d. Date of del Month	ivery Day Year
J.	that the the second sec		Part II. Other significant conditions co	ntributing to death but	not result	ting in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director, After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1	rsician: To the best of iner: On the basis of a and manner state	examinatio	ledge, death on and/or inv	occurred at the tile estigation, in my o	ne, date and place pinion, death occu	e, and due to the ca irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
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			30. Name and address of person who charlene Ozanne	ombleted cause of dea Lankfard.	M.D.	23a) (Type, P	rint)	re World	Blvd. S	ilver Spri	ng, MD 20906
	Sta		31. Date filed (Month, Day, Year)	32 Registrar			M. rersa	TE MOLIC		TIAGE ODET	g, 20000

Registrar DHMH 17 Rev 1/2001 NAR 1 0 2009 Situa S. Sansar ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Parker Drummond Wyman March 2009 9:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3806 Raymond Street Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, August 23, Birthplace (State or Foreign **Funeral** 1X M 2 □ F Months 339-16-0640 86 **Director** 1922 Illínois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt. If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, I'm. Medical Exact in at that is notified at uny or other traumatic event, I'm. Medical Exact in at that is notified at 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3806 Raymond Street 20815 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Eiementary/Secondary (0-12) Foreign Service Officer State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everet Lindley Wyman ပ Phyllis Mark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Howland Wyman/Wife 3806 Raymond Street, Chevy Chase, Maryland 20815 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot March 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 2009 21. Signature of Funeral Service License 22. Name and Address of Facility Funeral Home/Bethesda—Chevy Chase, Inc. M01546 OM 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Glioblastoma disease or condition resulting in death) Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 X No After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred s after decral Director: After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 24 hours a 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22775 March 3, 2009 our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr, M.D., 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day E 200 CARL ALLAN WAGNER 1.15A M larch 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SEASONS HOSPICE@ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05/08/21941 Birthplace (State or Foreign Country)
 MD 212-40-2387 Months Days Hours Min. 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2928 MARNAT ROAD. 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CREDIT COLLECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MANUFI WAGNER KATE GOODMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS CAROL WAGNER/WIFE 12928 MARNAT ROAD, APT. A BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/06/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) BETH TEILOH CONG 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. Mell le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ce of): DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

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Pages 1

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Baltimore, Maryland 21215-0036

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To the Funeral Director:
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Division of Vital Records, P.O. Box 68760,

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J.	Physician/
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Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	g cause given in Part I.		to use contribute to the cause of death?
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25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
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29h Signature and title of certifier	4		29c License number	204 [Pote signed (Month Paul Vess)

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State Registrar 31 Date filed (Month Year)

30. Name and address of person who com

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32 Registrar's Signature

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se of death (Item 23a) (Type, Print)

Smith

			1 - For State Registrar	State of N	Maryland		artmen rtificate			and M	lental Hy	giene Reg. No.	200	9	07	401
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	/Medi Examir		4a. Facility Name (If not institution, given 830 WEST 40TH STR	REET, #204	,		BALT	IMOF	Location o	ΓΥ	1,11(01)		County of E	Death		
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Baltimore,	permit. Pages 1 and Department of Health Important; If item 27 any Injury or other the ODCE.		4 ☐ Donation 5 ☐ Other (Special Signerary of Funeral Services Lice		HILL		ERVIC				LEVINS		BROS	1U T	NC	
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Ω	spital o		29a. Certifier 1 Certifying Ph	nysician: To the bes	st of my know	ledge, death	occurred a	at the tim	ne, date and	d place.	and due to the	cause(s)	and manne	r as sta	ted.	
	the Ho Tin 24 I the Fu	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis and manner	of examinati	on and/or inv	estigation,	in my op	oinion, deat	h occurr	ed at the time,	date and	place, and	due to tl	he cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 William S. Yamamoto March 3:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Collington Life Care Center Mitchellville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral X** M 2□ F Days 84 298-24-3970 SEP 22 1924 Ohio Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc nent of Health and Mental Hyglene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Propinal Exeminat must be notified a my or other traumatic event, the Propinal Exeminat must be notified as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Mitchellville 1 ☐ Yes 2 No MD Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Road 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1952–55 1 □Yes 2X No Specify. Specify: Asian ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
Health Care / 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Medical Doctor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sanada Soichi Yamamoto Toyo ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Ruth Yamamoto - daughter 14801 Dunbarton Drive, Upper Marlboro, MD Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 03/06/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens H Williams Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. physician the burial Physician/Medical ending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No ned by the Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed 1 □ Yes 2) No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Mapher of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year)

MAR 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

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1 Yes 2 Mo 3 Probably 4 L 24a. Was an autopsy performed? 1 Yes 2 Mo 3 Probably 4 L 24b. Was an autopsy performed? 1 Yes 2 Mo 3 Probably 4 L 24c. Was an autopsy performed? 1 Yes 2 Mo 3 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 24d. Was an autopsy performed? 1 Yes 2 Mo 1 Probably 4 L 25d. Place of Death (Check only one) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 L 25d. Place of Death (Check only one) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 L 25d. Place of Death (Check only one) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 L 25d. Place of Death (Check only one) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 L 25d. Death (Specify) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 L 25d. Death (Specify) 24d. Musring Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Probably 4 1 Yes 2 Mo 1 Proba	by th	hys						
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5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	as be	plet					24b. Were au	stopsy findings available
5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	The The	Š				performed?	death?	·
5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	/ITa	a	examiner?	7-		th (Check only one)		
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5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	Jn (ioi	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Inju			28d. Describe how inj	jury occurred	J
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5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	UIV alor A after i after I Direct	ertif	4 Homicide determined building, etc. (Specify)	, street, factory, office		City or Town, Sta	and Number or Hi ate)	irai Houte Number,
5 St. Namerand address of person who completed cause of reach (Item 23a) (Type, Print) Churches St. Balto. Md 20202	e Hospita 24 hours e Funera detely fille		(Check only 2 Medical Examiner: On the basis of examination and/	leath occurred at the ti or investigation, in my o	me, date and place ppinion, death occur	, and due to the cause rred at the time, date a	(s) and manner as	s stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. Ley Grand G70; N-Charles St. Balto. Md 2020x State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AR 1 0 2009 Leves A. Balto All Month, Day, Year)	To th Within To th	-	29b. Signature and title of certifier	29c. Licens	e number	29d. [Date signed (Monta	h, Day, Year)
30. Name and address of person who completed cause of person who cause of pe	/		If thathy they , and	1)2	5205	di	Hrch 9	2009
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AR 1 0 2009 AR 2 1 0 2009	5		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe Print)	les St. E	ratto mo	12020,	٠.
Registrar MAR 1 0 2009 Deleve D. Saules	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature					
DHMH 17 Rev 1/2001			MAR 1 0 2009 Cetus S. A	acked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 5:50 P ZEEMAN MARCH 03 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MD- TIMONIUM STELLA MARIS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/19/19/19/19/19/ 7. Age (In yrs. last birthday) Social Security Number e (State or Foreign **Funeral** 1 □ M 2 🕱 F 97 112-09-0328 Yrs NY Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD BALTIMORE TOWSON 1 ∐Yes 2 🔀 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 1314 HIGHLAND DRIVE Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** DISTILL UNION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANN CHARLES UNKNOWN ပ ZEEMAN 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADELE STRUMMER/FRIEND 1314 HIGHLAND DRIVE TOWSON. MD 21239 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🌠 Burial 2 □ Cremation 3 □ Removal from State BETH JACOB CONG. 4 Donation 5 Other (Specify) 03/06/2009 FINKSBURG.MD 22. Name and Address of Facility OL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) o 9 I Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an icate has l autopsy performed? /es 2 No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1∐Yes 2**X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOSPICE 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 X Natural 5 Pending thin 24 hours after death.

the Funeral Director: A puppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one X Nurse Practitioner as tated. 29a. Certifier Medical

ZEEMAN

2009

State

Registrar

29b. Signature and title of dertifier

JONES,

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

CRNP

29c. License number

29d. Date signed (Month, Day, Year)

Physician Medical Examined Mirian W. Assert Name First, Middle, Last	405	9 074		Mental Hygi		tment of h		ite of Maryl	Sta		for State Registrar			
Saminer 4a. Facility Name (if not hatbluton, pive afreet and number) 4b. City, Town, or Location to Death 4c. County of Deat		3. Time of D	Day Yea	2. Date of Death Month							1. Decedent's Nam	ian	Physic	
Social Social Social Number Social Social Social Number Social Number Social Number Social Number Social Number Social Soci	P."			February	r Location of Death	4b. City, Town, o		and number)						
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Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate events resulting in death) Sequentially list conditions, if any, leading to immediate events resulting in death) Leading to immediate events resulting in death in the resulting in the resultin)	ite, Zip Code) and 21770.	City or Town, State 1, Maryla	al Route Number, 0 Monrovia	and Number or Rur ne Drive,	Address <i>(Street a</i> hite Pin	19b. Mailin 3003						alth and 27 Is m	Mar
Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate events resulting in death) Sequentially list conditions, if any, leading to immediate events resulting in death) Leading to immediate events resulting in death in the resulting in the resultin		•	•	""	e) ¦	ory or other plac	cemetery, crem	from State	3 □ Removal	Cremation	1 DXBurial 2 D		Pages 1 a nent of He ant: If item ury or othe	imore,
Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwoen Such line. Due to (or as a consequence of):									Licensee	uneral Service I	21. Signature of Fu		permit. Departr Imports any inji	Balt
resulting in death) Due to (or as a consequence of):	ween	Approximate Approximate Interval Betwee Onset and Dea				the mode of dyin	th. Do not ente	that caused the dee on each line.	complications only one cause	(Final	Immediate Cause (Physician	
Due to (or as a consequence of): Continuous continuo						sease			a		resulting in death)			9
Section of the part of the p									c	nditions, imediate irlying injury s Last	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) L	<u>m</u>	e be executed sician and burial-transit	760, G
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24a. Was an autopsy findings a prior to completion of ca death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 16. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Death 28b. Date of Injury at Death injury occurred					n in Part I.	rlying cause give	sulting in the un	g to death but not i	ns contributing	icant condition	Part II. Other signifi	þ	quires tha	rds, F
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D		Specify)			at ;	28c. Injury Work	 		28a.	'n	27. Manner of Death	Certification: To	nding Phy ath. r; After this e funeral d	ion of
S P P P P P P P P P P P P P P P P P P P	ber,	r Rural Route Number	et and Number or F State)	28f. Location (Stree City or Town, S		factory, office	ome, farm, streety)	Place of Injury - At building, etc. (Spe	ot be 28e.	6 ☐ Could no		Sertific	al or Atte s after de: al Directo ed in by th	Divis
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Leaves number (20c. Leaves number))	er as stated. due to the cause(s)	se(s) and manner a and place, and du	and due to the caused at the time, date	e, date and place, inion, death occurr	ccurred at the tim tigation, in my op	owledge, death ation and/or inve	the basis of exam	xamıner: On	1 ☐ Certifying 2 ☐ Medical E	(Crieck offig		he Hospii in 24 hour he Funera pletely filk	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		onth, Day, Year)	Date signed (Mon	29d.	number	29c. License				title of certifier	29b. Signature and t	Ž	Vithi To th	
10 D26259 February 20, 2009	€	20, 2009	February		259		TI	ce	-	1/	10	-	10	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ava A. Kaufman 8218 Wisconsin Avenue, Suite 103, Bethesda, Maryland 2081	14	/land 2081/	la, Marvl	. Betheso	Suite 103							3		
State Registrar 31. Date filed (Month, Day, Year) FEB 23 2009 32 Registrar's Signature			, J =	,			ature	32 Registrar's Sig		h, Day, Year)	31. Date filed (Month			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marilyn Jean Ayers 10:15 AM FEBRUARI 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PL MEDICAL ENTER Charles 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🕏 F 216-24-6454 79 **Director** Jahuary 28,1930 | Washington DC Usual Residence of Decedent 10c. City, Town or Location death with the Marylan 10a, State 10b. County 10d. Inside City Limits 28a-f show event, it is Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20603 USA 11080 Weymouth Court, Apt. 420 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ERS, MARILUI ģ Specify: white 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, It a Magnes. 90ncs. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Torvestad Mabel Thornby ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Bobwhite Court, La Plata, MD 20646 Richard Avers/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/28/2009 Bladensburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22 AREHARI CECHOL'S FUNERAL HOME, P.A. aur 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 📉 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an s certificate has the lirector, page 2 s autopsy 1 □Yes nours after death.

neral Director: After this certifical y filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of beath 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 009 30. Name an eddress of person who completed cause of death (Item 23a) (Type, Print) BBio 6 POST OFFICE RO Suite 101 Waldorf, Md. 20602 Katyal 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07407 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 2009 Michael Lavon BRANT FEBRUARY 10 23 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) Oct. 11, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday)

Days

21750

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Months

10f. Zip Code

1 ☐Yes 2 🔣 No

stock clerk

Hancock

10c. City, Town or Location

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

1951

USA

18. Mother's Name (First, Middle, Maiden Surname)

J. Pauline Griffith

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: white

grocery store

16b. Kind of Business/Industry

Physician /Medical **Examiner Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is item to be a single or other traumatic event, it is item to be a single or other traumatic event. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner

For State Registrar

220-58-4142

10e. Street and Number

10a. State

Maryland

11. Marital Status

Directo

Funeral

q

Completed

Be

ပ

Usual Residence of Decedent

10b. County

6 West Main Street

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 🖾 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Donald L. Brant

Washington

15. Decedent's Education (Specify only highest grade completed)

1 M 2 □ F

57

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and alekty filled in by the funeral director, page 2 should be detached for use as the burnal-transet. physician and the burial-transit attending ph certificate has been signed by the rector, page 2 should be detached

Division of Vital Records, P.O. Box 68760,

	Name/Relationship				r or Rural Route Numi	her. City oi	Town State	Zin Code)
Virgini	a L. Sten	ger - cousin		Lee Street,				
20a. Method of D	isposition	20b. P	lace of Disposition (emetery, crematory		Date	20c. Lo	cation - City o	r Town, State
	Funeral Service Lice					nage	erstowi	n, Maryland
21. digitatare di	and the second	200	22. Nam	e and Address of Facility	MINNICH	FUNE	RAL HON	1E
20.0	Cour,	11 James	415	E.Wilson Bl	vd., Hager	stown	1, Md.	21740
SHOCK, OF HE	eart failure. List offiny	plications that caused the death one cause on each line.	Do not enter the	mode of dying, such as o	ardiac or respiratory	arrest,		Approximate Interval Between
Immediate Cause disease or condit	tion	Cardio	Pulme	- Ann	~			Onset and Death
resulting in death	1)	Due to (or as a consequ	ience of):	,				- mi
		meni	Enc	4Lepela	^			
Sequentially list c if any, leading to i	conditions, immediate	b. Due to (or as a consequ	ience of):					12000
cause. Enter Und Cause (Disease of that initiated even	or injury	- Shill	- Cer-	he De	= 17			
resulting in death)) Last	Due to (or as a consequ	ience of):			-		Fo ma
		0						
23b. Was decede	nt pregnant	23c. If yes, outcome of pregnar	ncy			2	3d. Date of de	eliverv
in the past 1: 1 □Yes 2 9 □ Unknow	No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		ic pregnancy (specify)			Month	Day Year
in the past 1: 1 ☐Yes 2 9 ☐ Unknow	! □No 'n	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 Other	(specify)	23e. Did t	obacco us		,
in the past 1: 1 ☐Yes 2 9 ☐ Unknow	! □No 'n	4 □ Pregnant at time of de 9 □ Unknown	eath 5 Other	(specify)	10.		e contribute t	Day Year
in the past 1: 1 ☐Yes 2 9 ☐ Unknow	! □No 'n	4 □ Pregnant at time of de 9 □ Unknown contributing to death but not result	eath 5 Other	(specify)	11	Yes 2	e contribute t	Day Year of the cause of death? robably 4 ☐ Unknown
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in the past I: 1	erred to medical No ath 5 Pending investigation 6 Could not be determined	4 □ Pregnant at time of de 9 □ Unknown contributing to death but not resu Hospital: 1 □ Impatient 2 □ E 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At horbuilding, etc. (Specify, yslcian: To the basis of examination of the part of the	ER/Outpatient 3 28b. Time of Injury Mme, farm, street, factively and/or investigate.	26. Place o Other: 4 \ \text{Nurs} 28c. Injury at \ \text{Work?} \ 1 \ \text{Yes} \ 2 \ \text{Nord} Other: 4 \ \text{Nurs}	24a. Was auto, person of Death (Check only of Death (Check only of Death (Check only of Death (Check only of Death (City or To)) 28f. Location (City or To) place, and due to the occurred at the time,	an psy primed? 2 12 140 pne) dence 6 how injury Street and wn, State) cause(s) a date and p	e contribute to No 3 P 24b. Were an prior to death? 1 Yes Other (Specoccurred	Day Year o the cause of death? robably 4 HMKnown utopsy findings available completion of cause of s 2 No actify) ural Route Number, s stated.

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 5 2009

To the Hospital of within 24 hours a To the Funeral D

JH-6

State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2/18/2009 Year **Physician** 2130 Leslie Albert Bates /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 🔀 M 2 🗆 F 5/30/1927 Director 216-22-3183 81 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Gambrills 1 TYes 2000 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21054 USA 963 Annapolis Rd. s 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene. Hem 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ™Yes 2 □ No 1945—
If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: White <u>م</u> Specify: 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Brown Edward Bates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 963 Annapolis Rd. Gambrills, MD 21054 Jean Bates 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baldwin UM Church Cem 2/28/2009 4 Donation 5 Dather (Specify) Millersville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signal re of Funer ervice Licensee Annapolis, MD 21401 12 Ridgely Ave. 1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or front ailure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cau te (Final ENA **Physician** disease or condi-resulting in death /Medical Due to (or as a consequence of) Examiner ARDIONYOPAT DILATED C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as the the attending p IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by to The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ANJUMONIA ASPIRATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed NECROTIFING. VASCULITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has b 24a. Was an autopsy certificate DIABETES 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA မ this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

STEPHEN C. HAMILTON, MO
ate filed (Month, Day, Year) 32 Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

116 DEFENSE HIGHWAY #400

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 855 AM February 2009 William Herbert Brushe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hagerstown Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 213-16-3913 June 26,1923 85 Maryland Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinatmust be notified at once. 1 ☐ Yes 2 No Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 U.S.A. 14105 William Talcott Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ WNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Poperty Management 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie H. Dehn Brushe ပ William H. Brushe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14105 William Talcott Lane Hagerstown, MD 21742 Audrey Brushe-wife altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 2-21-2009 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEGMENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed des gene and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 ☑ No 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ON 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑ No 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier will Dellar 2009 0061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-10) Guiel) Francisco 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Bosley Mary Elizabeth 2201 20 2009 reprugry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** umberland EGAN CAMPUS Memorial | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 11 9. Orthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday)
70 Yrs. 6. Sex Social Security Number **Funeral** Year) 1938 1 M 2000 219-34-1622 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County r than "natural", or items 23a or 28a-f show the Medical Evanning must be notified at Barton MD Allegany 1 ☐ Yes XXNo Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21521 United States 23521 Middle Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housework Homemaker 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha C. Bush William L. Bush Department of Health and Men Important: If item 27 is marked any Injury or other traumatic of ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23521 Middle St, Barton, Maryland Bob Bosley/ husband 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/24/ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Barton Maryland Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) $200\bar{9}$ 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pack line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 13 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 7 0 1 🗆 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate has al director, page 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Dale of Injury (Month, Day, Year) funeral 27. Moner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation atural 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce this 29c. License number DOG 33280 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Suite 101. Cumberland, Md 625

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01743 State of Maryland / Department of Health and Mental Hygiene Luther Lee Burrell 2009 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 1, 2009 Burrel1 1330 hrs Jr. Lee Luther Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death District Heights Prince George's 2909 Parkland Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Director August 15,193 Country) DC 578-44-9168 1 xM Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location iny 1XX Yes 2 28a-f show DISTRICT HEIGHTS PRINCE GEORGES or items 23a or 28a-f sho must be notified at once. MD with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. 20747 2909 PARKLAND DRIVE Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status or other traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married 2 x Married 1XX Yes BLACK Yes 2XX No specify Specify: Divorced f Yes. Give Year Widowed marked other than "natural", à more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours in the Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ UNITED STATES POSTAL TRUCK DRIVER 12th 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MABEL RUSSELL LUTHER LEE BURRELL SR. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 PARKLAND DRIVE DISTRICT HEIGHTS, MARYLAND 20747 19a. Informant's Name/Relationship (Type, Print) LILLIAN C. BURRELL/WIFE item 27 is 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place)
ARLINGTON NATIONAL Removal from State = Burial 2 XX remation 3 03-17-2009 ARLINGTON, VIRGINIA tant Donation 5 Other Specify: 22. Name and Address of Facility OHN T. RHINES FUNERAL HOME LLC 005 12th STREET N.E. WASHINGTON, DC 20017 21, Signature of Funeral Service Licensee Juan D. Smith (per DVR) 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Alcoholic ketoacidosis Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED #21, perFD, 23a,27,perME, g889 3/11/09 TT X UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death ned by the attendi 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? performed? page No Yes 2 . No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital uneral director Be examiner? Hospital: Inpatient DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 After this မ 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27 Manner of Death Certification: 1 X Natural Yes 2 No Pending within 24 hours after death. To the Funeral Director: the 2 Accident Investigation filled in by 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State 2009 Registrar

29b. Signature and title of certifier

Carol Allan, MD

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 2, 2009

30. Name and address of person who completed cause of death (Item 23a)

Q

Assistant Medical Examiner

			For State Registrar		State o	f Marylar		artment d rtificate d			ental Hyg	iene 20	09	07414
			1. Decedent's Name	(First, Middle	e, Last)						2. Date of Deat	th		3. Time of Death
	Physici /Medi		PAULINE	NOBLI	N COX						Februa:	ry ^{Da} 19, 2	2009	1:35 P M
and of	Examir		4a. Facility Name (If					4b. City, Tow		n of Death		4c. County	of Death	1
	-				ventist H			Rocky					gome	ry
	Funeral Director		5. Social Security Nu 229-24-9	261	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 You Months Da	ays Hour	er 24 Hrs. s Min.	8. Date of Birth (Month, Day July 10	, 1930	9. Birthp Cour Vir	place (State or Foreign ntry) ginia
	and ow		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation		_			1	0d. Inside City Limits
	Mary Fred	ţċ	MD	Montg	omery	Ge	rmanto	wn						1 ∐Yes 2 No
	h the	irec	10e. Street and Num					10f. Zip Co	de		1	0g. Citizen of W	/hat Coun	itry?
	th wit	a	12205 Pe	ach Cr	est Dr. #	H		2	20874			United	Stat	es
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantine in unit by northing at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 【 Widowed 4		Armed Fo	2) No ve		Vas Decedent f Yes, specify (I □ Yes 2 💢			cify Yes or No- Rican, etc.)	Blac	e - Americ k, White, c Whi	
5-(72 h	etec	(Specia	15. Decedent	's Education it grade completed)		I (Give	dent's Usual Od	one durina m	ast of warkin	a l	16b. Kind of Bu	siness/Ind	dustry
121	within ene. than '	뤁	Elementary/Secon		College (1	-4or 5+)	Cler	DO NOT use re	tired)		·	Cleaner		
d 2	filed Hygin Sther		17. Father's Name (F		Last)		OTC:		18 Mo	ther's Name	(First, Middle, N			
lan	ld be lental ked c	To Be	Elbert S	utphin					I		Mae Fin		·,	
Maryland	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Mental than the man and the mental than	_	19a. Informant's Na	me/Relations	nip (Type. Print)		19b. Mailin	g Address (Sti	reet and Nun	nber or Rural	Route Number,	City or Town,	State, Zip	Code)
	1 and 2 Health s tem 27 is		Dorothy	Cox (Daughter)			5 Peach				mantown		
Baltimore,	ges 1 it of He if iten or oth		20a. Method of Dispo		3 ☐ Removal from	20b. F	Place of Disponentery, cren	sition (Name o	f place)	Feb. Da	ate 20,	20c. Location -	City or To	wn, State
Ë	: Pag tment tant: jury		4 □ Donation			Met		tan Cr	,	2009		Alexand	-	VA
Bai	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr	-	21-Signatule of Fun	neral Service I	Licensee	rlQa					ol Fune r. Gait			20877
B	Physician /Medical Examiner -transit	Examiner	23a. Part1. Enter the shock, or heard Immediate Cause (F disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Under Cause. Enter Under Cause (Dease or that initiated events resulting in death) Le	ditions, nediate ying	a. Stro Due to (ke or as a consequer as a consequer	uence of):	er the mode of	dying, such	as cardiac or	respiratory arre	est,	2	Approximate Interval Between Onset and Death 2 Days
68760,	icate be executed physician and the burial-transit	dical E	roodsing in doday 20		d.	or as a conseq	uence of):							
Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mr 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	1 ☐ Live b	come of pregna birth 2 ☐ Feta nant at time of c	Ideath 3□	Ectopic pregn Other (specify				23d. Date Mor		ry Day Year
S, F	ires tha signed I be det	by P	Part II. Other signific	cant conditio	ns contributing to de	eath but not resi	ulting in the un	derlying cause	given in Par	t I.	23e. Did tob	acco use contri	bute to th	e cause of death?
ord	w require been si should b	ed	Pneumon	ia							1 □ Ye	s 2 □ No	3∏ Prob	ably 4 🙀 Unknown
	The la ate has page 2	e Completed	25. Was case referre	al to medical							24a. Was an autopsy perform	/ pi led? d	rior to con eath?	osy findings available inpletion of cause of
>	2 88	<u> </u>	examiner?		Hospital:	npatient 2 🗆	EB/Outpotion	27504	Othori		(Check only one			
o	g Phy ter thi neral o	n: To	27. Manner of Death		28a. Date	of Injury	28b. Time of	O D DOX	njury at Vork?		e 5 Reside			<u>) </u>
ior	Attending in death. Sector: After by the funer	atio	1 X Natural 2 Accident	5 Pending investig	ation	h, Day, Year)	Injury		Vork? ∐∐Yes 2[□No				
Divis	tal or Atters as after de al Directo ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could n determi	ot be ned 28e. Place buildir	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory, office	ce	28	Bf. Location (Str. City or Town,	eet and Numbe , State)	r or Rural	Route Number,
	To the Hospital or Atteno within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Medical E	Physician: To the xaminer: On the ba and mann	asis of examina	wledge, death tion and/or inv	occurred at the	e time, date ny opinion, d	and place, are	nd due to the ca d at the time, da	tuse(s) and mai	nner as st nd due to	ated. the cause(s)
	To the To the Complet	Σ	29b. Signature and ti	tle of certifier	Sli	(to no		ense number 38262	r		ed. Date signed		
			30. Name and address					h Blvd	• Roc	kville	e, MD 20	0850		
	Sta		31. Date filed (Month		0000 32,R									
	Registr	ar	FE	B 23	ZUUY CER	egistrar's Signal	1. pa	Mary.						

			State of Mary				•	3	
	•	For State Registrar			rtificate of			eg. No 2009	07415
Physiciar /Medica		1. Decedent's Name (First, Middle, Las Steven L. Caplar	•				2. Date of Dea Month Februar	Day Year	M
Examine		4a. Facility Name (If not institution, give	street and number)			or Location of Deat	h	4c. County of Dea	ath
Funeral		Casey House 5. Social Security Number 6. Se		yrs. last birthday)	Rockvil If Under 1 Year	If Under 24 Hrs			rthplace (State or Foreign
Director	-	220-42-3099 Usual Residence of Decedent	1 M 2 □ F 64	Yrs.	Months Days	Hours Min.	01/01/1	, rear)	yland
show aryland	_	10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
the Mg	25	Maryland Montgome	ry	Rockvill	e 10f. Zip Code		1.	On Citizen of What C	1 TxYes 2 □ No
3a or	ruileiai Director	401 King Farm Blvd	#303		Toi. Zip Code	20850	['	Og. Citizen of What Co	,
ems 2		11. Marital Status	12. Was Decedent Ever	n U.S. 13.	Was Decedent of h	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No-	14. Race - Ame	erican Indian,
15 a	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ No 19 If Yes, Give Year or Dates: 19	965-	1 □ Yes 2 🌁 No	Specify:	io riican, etc./	Black, Whit	White
in 72 h		15. Decedent's Edu (Specify only highest grad	le completed)	ı (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business	/Industry
21215-00 ed within 72 hou ygiene. ier than "natura t, the Wedical E	5	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		uter Prop	,		Computers	
be filed that Hyging other event, I	ומ	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	,	
aryland should be f and Mental s marked o umetic eve	2 .	Louis Caplan 19a. Informant's Name/Relationship (7)	ma Brinth	405 84-00			Garfinke		
and 2 sl ealth an n 27 is rier traum		Lillian Caplan, wi		401 I	King Farn	n Blvd. #	303, Roc	; City or Town, State, kville, MD	Zip Code) 20850
Baltimore, Mispermit. Peges 1 and 2 Department of Health a Department of Health a Important: If Item 27 is any Injury or other training.	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	removal nom state		sition (Name of natory or other place id Mam 1 (Gdns 02/2		20c. Location - City or	
Baltin permit. F Departm Importar any Injur	Ì	21. Signature of Further service Licens		22	. Name and Addre	ess of Facility	70 51	TION, INC.	ch, Virginia
- BD = 80	+	23a. Part 1 Enter the disease, or comp.	ications that caused the	10	<u> 191 Rocky</u>	ville Pik	e. Rockv:	ille. Marv	
Physician	ì	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.			ng, such as calula	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner			Due to (or as a con Valvular I						
executed in and ial-transit		Sequentially list conditions, if any leading to make the cause. Enter Underlying Cause (Disease or injury	Due to (or as a con Cirrhosis	amilineutic ret).					
760, Constitution of the properties of the prope	3	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
68760, tificate be exign physician es the burial edical Exignation			Coronary A	rtery Di	isease				
O. Box ne death cer the attendir hed for use	.,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
of Vital Records, P. Physician: The law requires that the this certificate has been signed by ral director, page 2 should be detacted.	: '	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause giv	en in Part I.		acco use contribute to	o the cause of death?
al Recorc							24a. Was an	24b. Were au	utopsy findings available
The law cate has page 2 s							autopsy perform 1 🗆 Yes 2	ned? death?	completion of cause of 2 □ No
Vital F slclan: The certificate irector, pag	1	25. Was case referred to medical examiner?	lospital:		Oth	OF:	th (Check only one		
ig Phys ter this neral dir		27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur Worl	4 LI Nursing H	ome 5 Reside	nce 6X Other (Spe w injury occurred	cify) Hospice
Sion (tending feath.) or: After the funer.		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(MONIII, Day, Tea	r) Injury		K? Yes 2 □ No			
Division c		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	t home, farm, stre ecify)	et, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
Divisi To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical		29a. Certifier 1⊠ CertifyIng Phy. (Check only one) 2□ Medical Examl	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the til restigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
To the comp		29b. Signature and title of certifier Tocelyne 10	ouesteho	u, mj	29c. Licens	e number 3 63 74 2		od. Date signed (Monti Sebruary 19	
	3	30. Name and address of person who co Jocelyn Toukep Kou				Parkway	, Baltimo	ore, MD 21	.218
State Registrar	3	FEB 23 2009	32. Registrar's Si	gnature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth Grace Callahan ам February 20, 2009 12:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Yrs 068-50-9650 Director 51 July 10, 1957 New York Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No D.C. Washington Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3910 E. Capitol Street, NE 20019 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Emminary once. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ပ Mary Louise Herbst -Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas William Jackson, III 3910 E. Capitol Street, NE, Washington, DC 20019 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee University Blvd. W., Silver Spring, MD 2090 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stook, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician Encephalopathy Ahoxic disease or condition resulting in death) weeks / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed Per physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed certificate has birector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an 1 ☐ Yes 2 12 No Hospital or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely (Check only one) To the I within 2 To the I 29c. License number D 5 2 8 / S 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Robert Alexander, MD 201 Millford Mill Road, Pikesville, MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 23 Registrar

			For State Registrar	State of M	aryland / De	partmen <i>ertificat</i>			and Me		giene Reg. No.2009	9 07417
	Physici		1. Decedent's Name (First, Middle, La Arthur Bori	*		-			2	. Date of Dea		3. Time of Death 1:20 a M
	/Medi Examir		4a. Facility Name (If not institution, given Carroll Hospice D	,				Location of	f Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 268–22–3452 Usual Residence of Decedent	ex 7. Ag	e (In yrs. last birthd 82 Yrs	Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day Dec 26	, Year) 9. B	irthplace (State or Foreign Country) 110
	Maryland f show	tor	10a. State 10b. County Maryland Carrol	1.	10c. City, Town or	Location	We	stmin	ster			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	ath with the Maryla s 23a or 28a-f shows well be notified at	Funeral Director	10e. Street and Number 320 North Denton	Drive		10f. Zip	Code	211	57	1	l 0g. Citizen of What (Country?
920	after de	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Myes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Specit Puerto Ric	fy Yes or No- can, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. white
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	i+) (G	cedent's Usua ive kind of wor e. DO NOT us eration	rk done d e retired,	uring most			16b. Kind of Busines Engine	·
land 2	s 1 and 2 should be filed within the alth and Mental Hygiene. Item 27 is marked other than other traumatic event, The Mental Control of the traumatic event, The Mental Control of the traumatic event, The Mental Control of the Mental Office	To Be C	17. Father's Name (First, Middle, Last, Arthur Borisky					18. Mother	's Name (F	First, Middle, N ulligar	Maiden Surname)	
	es 1 and 2 sho of Health and I Item 27 is ma r other traums		19a. Informant's Name/Relationship (Bernice Borisky,		320	N Dent	ton I	Drive,	r or Rural F West	Route Number tminste	r, City or Town, State, er, MD 211	Zip Code) 57
Baltimore,	Page rent o nt: If		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Place of Discemetery, of Evergre	en Memo	oria.	L 2	Date 2/26/2	2009	20c. Location - City o Finksburg	, MD
Balt	permit. Departm Importa any Inju		21. Signature of Funeral Service Licer	Sutro		22. Name and 91 Wil	d Addres Llis	s of Facility Stree	Mye et, We	rs-Durk estmins	ooraw Fune ster, MD 2	ral Home 1157
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fairly leading or inhead cause. Enter Underlying Cause (Disease or injury that initiated events	a	a consequence of):	1200		such as o			est,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dical	resulting in death) Last	Due to (or as	a consequence of):							
O. Box 6	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (spe	egnancy ec <i>ify)</i>				23d. Date of do Month	elivery Day Year
ords, P.	equires that en signed b ould be deta	ē	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying ca	use give	n in Part I.			,	to the cause of death? Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. Within 14 hours after death. completely filled in by the funeral director, page 2 should be detached	Completed							_	24a. Was ar autops perform 1 🗆 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
₹	rsiclar s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Nø	Hospital:	nt 2 ☐ ER/Outpat	inst 2 DO	Tothe			heck only one	LI	ospice
ion of	nding Phy ith. : After this e funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 28b. Time		Bc. Injury Work?	4 LI Nurs	28d	5 ☐ Reside	w injury occurred	ecity)
Divis	tal or Atters s after dea al Director ed in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	iry - At home, farm, c. (Specify)	street, factory,	office		28f.	Location (Str City or Town	reet and Number or F , State)	tural Route Number,
	he Hospi in 24 hour he Funer: pletely fill	Medical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	ysician: To the best on niner: On the basis of and manner sta	examination and/or	ath occurred a investigation,	at the time in my op	e, date and inion, death	place, and occurred	due to the ca at the time, da	ause(s) and manner a ate and place, and du	e to the cause(s)
	Marie	Z	29b. Signature and title of certifie	She			License		(750		Od. Date signed (Mon	
_	6tIVA		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print) 410 M	akdi	n Ori	ve S	ec-We	estminster,	MO ZIST
	Sta Registra		31. Date filed (Month, Day, Year) FEB 23	completed cause of de 32. Registra 2009	ar's Signature	park	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Anthony Colodonato 18, 2009 1920 February /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Carroll Hospice Dove House if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 21 1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months 15 M 2 □ F MD Director 216-44-8300 65 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 XNo Director Westminster Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2197 Sams Creek Rd. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1월 Yes 2□No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner ma 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iter any Injury or other traumatic event. the Medical Evandance. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: 2 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Agent FBI Δ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Nichols Antonio Colodonato 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Colodonato/wife 2197 Sams Creek Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/2372009 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Meadow Branch Cemetery Westminster, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee 412 Washington Rd. Westminster, 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each live. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due lo (or as conse uence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use cooribute to the cause of death? 1 ☐ Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy nerformed 2[or Attending Physician: 25. Was case referred medical examiner? funeral director. Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manney 1 eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation atural To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier

1JL 10+1VA

> State Registrar

30 Name and address of p

31. Date filed (Month, Day,

FEB 2

DHMH 17 Rev 1/2001

empleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

09-01557 Keith Eugene Brown

Please Type or Print in Black Indelible Ink. Essure All Gogies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death

2009 07419

Physicia		Registrar			are or be				Reg. No.		
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MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than	ို	19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailing Add	ress (Street and	Number or F	Rural Route No	umber, City o	or Town, State	e, Zip Code)
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/Medical		failure. List only one cause o	n each line.			, 0,			,		Between Onset and
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year 2.10 AM KaMa 7 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner (ente If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number unk 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Year 1 □ M 2 N F Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the McCital Event har mart be notified at Director 1 ☐ Yes 2 No pol 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ aria 19a. Informant's Name/Relationship (Type. Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: If item 27 is any injury or other trau ms 2/1/02 60 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 TX Cremation 3 ☐ Removal from State Atlantic Crematory 2/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Treme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): physician at the burial P.O. Box 68760. Physician/Medical attending properties for use as use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has birector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 1 ☐Yes 2 ☐No 2 X No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzanne Rindfleisch 2001 Medical Pkwy. Annapolis, MD 21401

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 0 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:30 PM Sara Lou Davhoff 16,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Washington County Hospital Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 8. Date of Birth (Month, Day, Year) Jan. 3,1942 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 1 X F 214-42-0971 Jan. 67 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Georgiæ Ave. Funeral 21740 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Branch Administrator Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Franklin Burkett Dris Margaret Ashby Burkett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry W. Dayhoff-husband 715 Georgia Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Hill U. Church Cemetery 2-20-2009 Greencastle, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** SULDS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by moro 1 Yes 3 Probably 4 Unknown 2 🗌 No 64 24b. Were autopsy findings available 24a. Was an autopsy 2 🗆 No 1 □Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) person who completed cause of death (kee 30. Name and 23a) (Type 3H-4 Registrar's Signature Year, State FEB 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan				/lental Hyg	iene nng	07423
			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	rtificate of l	Jeain	2. Date of Deat	eg. No.	3. Time of Death
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	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1 CDI GHI y	4c. County of Dea	
<u>/</u> _			Glen Burnie Hea	lth & Rehab		Glen	Burnie		Anne Ari	ındel
	Funeral Director		5. Social Security Number 6. Se	ТМ 2∏ Е	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign ountry)
			218-30-1552 Usual Residence of Decedent	74				July 18,	1935 West	t Virginia
	arytan show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	the Mi	Directo	Maryland 10e. Street and Number		Baltimo	10f. Zip Code		1.	og. Citizen of What C	1½ Yes 2 No
	3a or	Ö	3800 West Belveder	a Avenue An	. 407	2121	5			,
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Micdical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Am	es of America erican Indian,
0	or ite	by Fu	1 ▼ Never Married 2 Married	1 ∐Yes 2 🙀 No If Yes, Give	-	l □Yes 2√⊊No	Specify:	nican, etc.)	Specify:	ie, etc.
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Ž	2 should be and Mental is marked of raumatic even	은	William A1 19a. Informant's Name/Relationship (T	bert Holthaus	T-				Bishoff City or Town, State,	Zin Cada)
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e,	es 1 a of Hea fitem rothe		20a. Method of Disposition	20b. f		sition (Name of natory or other place			20c. Location - City or	
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ם	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If It Mudical Examinar must be notified at once.		21. Signature of Funeral Service Licens	love	Mo 12	Name and Address ore Fune: South Se	ss of Facility ral Home, econd Str	P.A. eet. Den	ton, Maryl	and 21629
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			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type,	Hickory.	C1.1 6	O. Ru	nu MD	21061
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		For State Registrar		٤	State of M	larylan		epartme C <i>ertifica</i>			id Me	ental Hy	giene Reg. No		09	0742	24
		Decedent's Nam	e (First, Middl	e, Last)						<i>-</i>	2	2. Date of D	eath			3. Time of Death	1
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Menta	70 E	Timoth				Esther	ramm	na Jan	anraspalli umber, City or Town, State, Zip Code) e, Germantown, MD 20876 20c. Location - City or Town, State Germantown, Maryland cal Home Inc.								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Ever, Incrined by Indiffed a once.		19a. Informant's N Vijay K															
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nding Physician: th. : After this certifics ? funeral director,	Certification: To	27. Manner of Deat 1 🔀 Natural	5 Pendin		28a. Date of Inj (Month, D	ury a <i>y, Year)</i>	28b. Tin Inju	ıry	28c. Injur Worl		28	d. Describe	how inju	ry occurred		·	
death ctor: y the f	ficat	2 ☐ Accident 3 ☐ Suicide	investi 6	not be	28e. Place of In	iurv - At ho	ome farm	M street, facto		Yes 2 □ No	28	f Location	(Street or	nd Number	or Pur	al Route Number,	
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10		30. Name and add	ess of person		oleted cause of	death (Iten	n 23a) (Tu		0658	130			Felg	van	, 2	1,2009	
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Stat Registra	_	31. Date filed (Mon	B 23	2009	Our Regist	rar's Signa	1. 4	harles									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 2:05p M Herman E. Davis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery The Lutheran Home Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs, last birthday) Year. 1⊠M 2□ F Months Days Hours March 577-22-7204 86 DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9701 Viers Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify 3 X Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seal Test Dairy Dairy Man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Davis Frances Diggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursuline Singleton/Daughter 11116 Lake Victoria Lane, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln 2/21/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Ligensee 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PLEURAL disease or condition resulting in death) Due to (or as a consequence of): CONGESTIVE HLMRI Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the incomplete of the cause Due to (or as a consequence of): FAIL to (or as a consequence of): MIMIA outcome of pregnancy ve birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy egnant at time of death known 5 ☐ Other (specify) death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical Examiner

Physician

/Medical

Examiner

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th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Health tem 27 i

Department of Heali Important: If item 2 any injury or other once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Examine Completed by Physician/Medical Be

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 Yes 2 No Certification: To

resulting in death) Last	Due t					
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, of 1 ☐ Liv 4 ☐ Pro					
Part II. Other significant condition	ons contributing to					

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be

3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

DO051158

ROCKVILLE

2 □ No

2009

FIRRUARY

no 20850

29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Muertla da 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

DRIVE VERS 701

32. Registrar's Signature

VATI ANTHOMY 31. Date filed (Month, Day, Year) State Registrar

within 24 hours a

To the Funeral C

completely filled

To the

Medical

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19, 11:15 A M JOHN DIETZ February 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6240 Glenn Valley Terrace, Apt. D Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours Min Yrs. Maryland Director October 22, 1932 216-28-9832 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 K No Director Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 6240 Glenn Valley Terrace, Apt. D Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify. g Specify 3 Widowed 4 Divorced Korea White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) lal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Orange Juice Company Maintainance Engineer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F ۵ James Dietz Alice Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tratonce. 6240 Glenn Valley Terrace, Apt. D, Frederick, Maryland 21701 Lena M. Dietz - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of FacilitHines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 month Metastatic Small Cell Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the drift is Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ŧ, attending pl IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 X No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\tilde{\mathbb{N}}\$ Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41866 February 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46 "B" Thomas Johnson Drive, Kanan Hudhud, M.D., Frederick, MD 21702 State Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 6:38 pM Charles Dixon February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6419 81st Street Cabin John Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days 1 X M 2 □ F Months Hours Min Director 219-04-0125 March 21, 1972 District of Columbia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 🕱 No Maryland Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6419 81st Street Completed by Funerai 20818 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No Specify 3 Widowed 4 Divorced African-American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney AFLCIO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Kenneth Dixon Adrian Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Dixon - Father or other 81st Street, Cabin John, Maryland 20818 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 03/03/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) uno /Medical Du lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Exami and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death Month Day Year signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has autopsy certificate 1 □Yes 2 ZNo 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. Director: d in by the f 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide in 24 hours the Funeral Dire Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the within 7 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) AdRIAN 31. Date filed (Month, Day, Year) FEB 24 Registrar's Signatu State Registrar

			For State Registrar		State of	f Mary		artment of F rtificate of		Mental Hy	giene Reg. No	/11119	074	:28
			Decedent's Name (First)	Middle, La	st)					2. Date of De	eath		3. Time of	Death
	Physicia /Medic		Eunice	Burd	lick	Demu	th			Feb.	Day	y Year 9, 2009	7:30	РМ
7	Examin		4a. Facility Name (If not in	_		nber)			r Location of Death	1	1	County of Death		
			5404 Bradle 5. Social Security Number			7 100 //0	use loot hirthdou	Beth If Under 1 Year	nesda If Under 24 Hrs.	8. Date of Bi	rth	Montgome		- Fi
Ŀ	Funeral Director		216-46-1852		ex □M 2X1F	7. Age (III	yrs. last birthday) Yrs.	Months Days	Hours Min.	Feb. 21	ay, Year)	Cou		r i-oreign
	ryland how at		Usual Residence of Deced 10a. State 10b. 0	County		100	c. City, Town or Lo	ocation					10d. Inside Cit	-
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 3 ★Widowed 4 □ Di		Armed Fo 1 Yes If Yes, Giv Year or D	rces? 2 ∑ No ⁄e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21\$No		o Rican, etc.)		Black, White,		
2-0	72 ho	eted	15. Do	ecedent's Ed	ducation ade completed)		16a. Dece	dent's Usual Occup	ation during most of wor	kina	16b. K	ind of Business/Ir	dustry	
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/lar	uld be Ments Irked	ToE	George Burd	ick					Anne	Chase				
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Baltimore, Maryland 21215-0036	Pages 'ment of H ant: If Ite ury or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cren 4 ☐ Donation 5 ☐ C	nation 3			Metropo Cremato	matory or other plac litan rv	20	22, 09		xandria,		nia
Balt	permit. Depart Import any inj		21. Signature of Fun Fal S	Service Lice YWY A	1 ee)		2. Name and Addre	יע	eVol Fur			D.C. 2	0007
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68760,	ficate be executed physician and is the burial-transit	edical E		l	_d				****					
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Divis	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	Zoe. Place	of injury - ng, etc. <i>(S</i>	At home, farm, st pecify)	eet, factory, office		28f. Location (City or To		nd Number or Run e)	al Route Numb	per,
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			30. Name and address of					,	030 Cha	, Char	LM	20015		
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	/Medic	al	4a. Facility Name (If not institution		abor)		4h City	Town or	Location of		Februai		2009 ounty of Deat	9:30	A M
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	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	City Limits
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventure. Aust be retified at once.	by Fui	11. Marital Status 1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 X No	Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 🎇 No <i>Specify:</i>				ecify Yes or N Rican, etc.)	fy Yes or No- can, etc.) 14. Race - An Black, Wh Specify: B				
5-0	72 hou	sted	15. Decedent			16a. Dece	dent's Usua	Occupa	ation	t of worki	na	16b. Kind	of Business/	Industry	
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12	lled w Hygier ther th	ပ္ပ	17. Father's Name (First, Middle,	3		Sec	retai		18 Moths	are Namo	(First, Middle	Law Maiden St	(mame)		
Baltimore, Maryland 21215-0036	Mental be fi Mental barked ot arked ot	To Be	Earl Mitchel		, Sr.				Chr	isti	ne Mar	ie Tol	liver	·	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relations				-	•			and, Ma			'	
نه	1 and Healt tem 2	}	Christine E	Ivans / Mo		lace of Dispo					atte Fie		tion - City or		
οu	ages ent of it: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Removal from S	state	_{emetery, c<i>i</i>er Lantic}				12/21	/2009			e, Mary	71and
3altii	Departmit. F Departmit mportar nny Injur		21. Signature of Funeral Service			22	Name an	d Addres	s of Facilit	h	Servi Silver	1.			Zana
	402 60		23a. Part 1. Enter the disease, or	complications that ca	MO09								g, MD		te
d	Physician /Medical Examiner		shock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions.	a. <u>CONG</u> Due to (c	ESTIVE or as a consequ	ence of):	FAILU	IRE						Approxima Interval Be Onset and	tween Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consequ										
P.O. Box 6	ne death certifi the attending hed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		irth 2 🗆 Fetal ant at time of d	death 3	Ectopic p		′			23	d. Date of del Month		Year
	s that gned t		Part II. Other significant condition	ons contributing to de	ath but not resu	ılting in the uı	nderlying ca	ause give	n in Part I		23e. Did	tobacco use	contribute to	the cause of	death?
g	equire en si	pa	HYPERKALEMIA,	END STAGE	RENAL	DISEAS	SE				1 🗆	Yes 2□	No 3□ Pr	obably 4X	Unknown
Division of Vital Records,	The law rate has be	Completed by									perf	s an opsy ormed? 2 X INo	24b. Were au prior to d death? 1 □ Yes	topsy findings completion of a	available cause of
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7	hysio this c		1 Yes 2 No		npatient 2				4 17 140		me 5□Res			cify)	
ü	ling F	ioi	27. Manner of Death 1 X Natural 5 ☐ Pendin		of Injury h, Day, Year)	28b. Time of Injury	M 2	Bc. Injury Work	rat ? Yes 2□		28d. Describe	how injury o	occurred		
ivisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be	of Injury - At ho ng, etc. <i>(Specif</i>)	me, farm, str			res Z		28f. Location City or To	(Street and I wn, State)	Number or Ru	ıral Route Nur	nber,
	Hospital 4 hours a 5 uneral [ety filled		(Check only 2 Medical	g Physician: To the Examiner: On the ba	asis of examinat	wledge, deat	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to th	e cause(s) a	nd manner as	s stated.	s)
	thin 2 the 1 the 1	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		290	. License	numher			29d Date	signed (Monti	h Day Year)	
	F ≱ F 8	-	S. Signalard and the Di Cei tille				230		64502					, 2009	
	'		30. Name and address of person	who completed cause	e of death (Item	23a) (Tvpe	Print)	_ 500						,	
			BRIAN CARPENTI	-				ER DE	R., R	OCKV	ILLE,	MARYLA	ND 208	350	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 23	2009	egistrar's Signat	ture	west.								

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	•	For State Registrar	ato of maryi	-	rtificate of			g. No. 2005	07430
		Decedent's Name (First, Middle, Last)					2. Date of Death	n Day Year	3. Time of Death
Physicia /Medic				lis, II			February	22, 2009	
Examin	er	4a. Facility Name (If not institution, give street				r Location of Death	1	4c. County of Dea	
Funeral		Montgomery Hospice C 5. Social Security Number 6. Sex		e vrs. last birthday)	Rockvi	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Montgo	rthplace (State or Foreign
Director		578-54-6457 1CXM 2	^{1□ F} 6	6 Yrs.	Months Days	Hours Min.	Nov. 28	1942 Ne	w York
pu "		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
Aaryle f sho	or			German					1 □Yes 2 No
If a 12 (3-10) oo filed within 72 hours after death with the Maryland Hygiene. Hygiene with the market show with the Modeal Evan in a ment to maiffed at	Director	Maryland Montgomery 10e. Street and Number	/	German	10f. Zip Code		10	0g. Citizen of What C	ountry?
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r deat	Funeral	Ar Ar	as Decedent Ever in med Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
ural", or it	by Fi	If \	☑gYes 2 □ No] Yes, Give ear or Dates:]	961- 964	1 □Yes 2 X No	Specify:		Specify:	hite
2 hour	led	15. Decedent's Education (Specify only highest grade comp		16a. Dece	edent's Usual Occup			16b. Kind of Business	
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and lbe fil intal H ed otl	Be	17. Father's Name (First, Middle, Last)	14_			18. Mothers Nan		,	
should should nd Me mark imatic	은	Malcolm El 19a. Informant's Name/Relationship (Type. Pr	lis	19b. Maili	ng Address (Street	and Number or Ru	Kathryn Iral Route Number	Doolii City or Town, State,	
ife, INTAINITY INTINCENTIFY AND SOON SET AND SOON SET AND 2 Should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene them 27 is marked other than "natural", or items 28a or 28a-f show other traumatic event, the "Moderal Even line" and the multilized at		Katherine P. Ellis/Wi		3 Ind	lian Gras	s Court.	Germanto	wn,_Maryla	and 20874
DallIIIIOCF, INE permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove	20		osition (Name of matory or other pla			20c. Location - City of	
annicor rmit. Pages spartment of portant: If it y injury or o	١,	4 □ Donation 5 □ Other (Specify)						lexandria	Virginia
Dearnit Depart Mport any in	_	21. Signature of Funeral Service Licensee	2100		2. Name and Addre				ND 00077
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Dhysisian	2 9	shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.				, , , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death
Physician /Medical		resulting in death)	Jung Cance Due to (or as a cons						
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ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or right) that initiated events c	Due to (or as a con-	sequence of):					
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ecords, law requires as been sign 2 should be	ed by						1 ☐ Ye	s 2 No 3 F	Probably 4∑ Unknown
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On ding th. : After	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea		Wo	rk?]Yes 2 □ No	200. 20001150 110	m mjary occanica	
VISION Attending or death. rector: Afte	ifica	o □ outside 6 □ Could not be	e. Place of Injury - A building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or F	Rural Route Number,
Ital or Ital o	Certification:	Tiomoide	building, etc. (op				Ony or Your		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier 1⊠ Certifying Physician (Check only one) 2□ Medical Examiner: 0							
o the vithin of the omple	Mec	29b. Signature and title of certifier.	na mariner stated.		29c. Licen	se number	2	9d. Date signed (Mor	oth, Day, Year)
		I have trans			D	64615	1	February 2	3. 2009
12+1		30. Name and address of person who complete	ted cause of death	(Item 23a) (Type				cordary 2	J, 2007
		Genevieve Wroblewski,			ard Drive	e, Suite	100, Rock	cville, MD	. 20850
Sta Registr		31. Date filed (Month, Day, Year) FEB 2 4 2009	32 Registrar's S						
DHMH 17 Rev 1/2		FED & 4 2003	Cliens	a. ga					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 07431 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Year PM 6:25 Ray Foster Everts February 25 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral 1** M 2 □ F Months Days Hours Min. 186-28-3825 Director 16/1934 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event that 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo X□Yes 2□No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 West Baltimore StreetAPT81 21740 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Sawmil1 Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Foster Everts Barnhart Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 9 Waynesboro, Pa. 17268

Date 20c. Eccation - City or Town State Darlene Pittman (Daughter) 13101 Welty Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Geisel Crematory 2/27/2009 Chambersburg, Pa. 22. Name and Address of Facility Howard L. Sipes FuneralHome 21. Signature of Funeral Service Licenses Taril sweller P.O.Box 677 McConnellsburg, Pa. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spiration **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner D15295-Coronav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and elely filled in by the funeral director, page 2 should be detached for use as the burial-transit Diabete Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jahnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 110 1 □ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-HCD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State **FEB 27** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_	For State Registrar					ite of L		Mental Hy	Reg. No	711119	07432
Physicia /Medic		1. Decedent's Name (First, Middle, La Corror Fley	TCHER						2. Date of D Month		ay Year 2 <i>0.</i> 09	3. Time of Death 2:45 PM
Examine Funeral Director		4a. Facility Name (If not institution, gi Huspice of Care 5. Social Security Number 579-24-6030	ve street and number)	£	as <i>t birthday)</i> Yrs.	(en	er i Year	Location of Deal		rth ay, Year	r) Co	th Arve's thplace (State or Foreign unity) Illinois
ylanu how		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
28a-f sl	Director	Maryland Prince Go	eorge's			10f. Z	Upper	Mar1boro		10a. C	itizen of What Co	1 ☐ Yes 2 ☒ No
23a or		13504 Messenger P						20774			U.S.	.A.
ra nous are oean win ne wayano hatural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:			f Yes, sp	edent of Hi ecify Cubar 2⊠No	spanic Origin? (s n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
I feath and Mental Hygiene. Heath and Mental Hygiene. The the straumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	life. L	kind of v DO NOT	vork done d use retired,	uring most of wo	rking		Kind of Business/	Industry
other t	Be င	17. Father's Name (First, Middle, Las	5+ t)		Experi	menta	I Psyc	hologist 18. Mother's Na	me (First, Middle		S. Governm	nent
and Mental s marked o tumatic eve	2	Gordon Van B		, Sr.	T			(Unknown)				
Health and em 27 Is me wither traums		19a. Informant's Name/Relationship Phillip A. Fletcher					,	waldorf,			or Town, State, 2 13	Zip Code)
o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	CE	ace of Dispo emetery, cren Lincol	natory o	other place	1	Date 23/2009		Location - City or	
Department Important: I any Injury o once.		21. Signature of Funeral Service Lice	nsee	+	H	ines	-Rinald	s of Facility i Funeral mpshire A	Home, Invenue, Si	c. lver	Spring, Ma	aryland 20904
hysician /Medical		23a. Part1. Enter the distase, or conshock, or he ut time. List only Immediat Lause (Final disease or condition resulting in death)	nplications that caused one cause on each li a. Due to (or as			er the m	ode of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
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physicia the bur	edical Exa	resulting in death) Last	Due to (or as	a consequ	ence of):		•					7
0, 4	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3		pregnancy				23d. Date of del Month	ivery Day Year
be d	2	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the ur	nderlying	cause give	n in Part I.				the cause of death?
page 2	Completed					24a. Was auto perf 1 □Yes	psy ormed?	prior to death?	ntopsy findings available completion of cause of			
8 8	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 🔲	ER/Outpatier	t 3 🗆 1	OOA Othe	26. Place of De r: 4 ☐ Nursing I			6 ☑Other (Spe	cifv) HQA
ath. r: After ne funei	Certification: 1	27. Manner of Death 1		y, Year)	28b. Time of Injury	M			28d. Describe	how inju	ury occurred	(Hospite)
		4 ☐ Homicide determined	bullaing, et	c. (Specify	")				City or To	wn, Stat	te)	ıral Route Number,
n 24 ho he Fune pletely 1	Medical	29a. Certifier (Check only one) 1 ☑ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner st	f examinat	ion and/or in	vestigati	on, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time	e cause(, date ar	(s) and manner as nd place, and due	s stated. to the cause(s)
10 00 E	Ž	29b. Signature and title of certifier				2	9c. License			29d. D	ate signed (Monti	h, Day, Year)
5+1		30. Name and address of person who	completed cause of c			4.	V 637				2/19/09	
	e	JEFF-REY UKGAS 31. Date filed (Month, Day, Year)	32. Registr	2540 ar's Signat	Ure -	eville	201	s, lens	reville m	216	617	

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Yohannes Fikre February 18 2009 2130 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1⊠M 2□F 216-08-6199 Director Ethiopia 35 March 15. Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20910 1215 East West Highway, Apt. #509 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Black, White, etc. ∐Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced R1ack Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed withir al Hygiene. I other than Elementary/Secondary (0-12) College (1-4or 5+) Shift Manager 12 Parking Lot Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be file f Health and Mental Hi tem 27 is marked oth Be P Fikre Habtemariam Ayelech Alemu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Asrat Woldemichael - Brother-in-law 3004 Silver Lake Court, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery | 02/21/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Nonce 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm Cause (Final **Physician** disease or condition resulting in death) Se sis /Medical Due to (or as a consequence of): Examiner Pneumonia Pneumocystis Carinii Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed Acquired Immune Deficiency Syndrome burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Dunknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate 1 ☐ Yes 2 K No 2 No 1 ☐ Yes To the Hospital or Attending Physician; 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 🔼 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No l Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are. To the Funeral Direct determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Pateldayonti 10052586 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti Lalbhai Patel, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ii yiariu /		tificate of i		vieritai i iy	Reg. No		3 07434
	Physicia	an	1. Decedent's Name (First, Middle, Las Majura Emma I						2. Date of De Month	Da		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		711		4b. City. Town, or	Location of Death		24,	2009 County of Dea	10:15A [™]
	Examin	er	Manor Care									more
H	Funeral Director		5. Social Security Number 6. S 219-14-3371 1 Usual Residence of Decedent	ex 7. Age	9 2	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Mar. 3	th $_{ay, Year}$, $_{19}^{rth}$	17 9. Bir Cc De	thplace (State or Foreign ountry) Laware
	yland iow		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	e Mar 8a-fsl	ctor	DE Susse	X			Seafor	r d				X XYes 2 No
	a with th	al Dire	10e. Street and Number 332 North Mark	et Stree	t		10f. Zip Code 199	973		•	itizen of What Co ited St	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 25 1 If Yes, Give Year or Dates:			Nas Decedent of H fYes, specify Cuba I □Yes 2 🗓 No		pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
2-0 -0	"natura	Be Completed by	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	(Give	dent's Usual Occup	during most of worl	king	16b. k	Kind of Business	/Industry
2121	l within glene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo NOT use retired eptionis			C.	lerical	L
⊆	ild be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Walter Canno					18. Mother's Nam	ie (First, Middle Le Smi		n Surname)	
, Mary	and 2 should ealth and Mer n 27 Is marke ner traumatic		19a. Informant's Name/Relationship (Charlotte Robi	^{Type. Print)} , Grai . n s o n /daugh	ter 4	458	www. Address (Street	Street,				
ē	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		20b. Place ceme Mid-	Shor	sition (Name of natory or other place re Crem	Ctr 2/2	Date 26/09		ocation - City or nbridge	Town, State e, Maryland
Balt	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licer	CF5P	8.9		Name and Addre		ramptor Federals	m Fu sbur	uneral g, MD 21	Home 1632
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin		er the mode of dyir		or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner			Due to (or as	a consequenc	ce of):						
	it ø	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	ce of):						
, O	trificate be executed g physician and as the burial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):						
68760,	trificate b ng physic as the br	ledical		d								
	Attending Physician: The law requires that the death certificate in death. **redeath.** **redea	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	у			23d. Date of de Month	elivery Day Year
o, O	is that gned b ie deta		Part II. Other significant conditions of	_		_		en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
ord	w requires t been signe should be	ted		ARMOVAS			458458		1 🗆	Yes 2	2) ⊠ No 3□ P	robably 4 Unknown
Vital Records,	hysician: The law i his certificate has b I director, page 2 sh	Completed by	URINARY TRI	tu in	IFELT	107			24a. Was auto perf 1 ∐Yes		prior to death?	utopsy findings available completion of cause of
Zita	sician certifii rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	26. Place of Dea				
ot	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Inju (Month, Da		Outpatier D. Time of Injury	N 3 LI DOA I	y at	ome 5 ☐ Res 28d. Describe		6 ☐ Other (Spe iry occurred	ecify)
sion	tending Fileath. tor: After the funera	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	n	y, real)	injury		Yes 2 □ No				
Division of	al or Attences after death safter death	Certification: To	3 Suicide 6 Could not b 4 Homicide determined		iry - At home, c. <i>(Specify)</i>	farm, str	eet, factory, office		28f. Location City or To			lural Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical (nysician: To the best niner: On the basis o and manner sta	examination							
	To the within 2 To the comple	M	29b. Signature and title of certifier				29c. Licens				ate signed (Mon.	
			M.D.		ooth /lt CO	a) /T:===		59107		2-	-25-	2007
			30. Name and address of person who	20 Bush	≈ESJ (a) (Type,	TER DRIV	E REI	STERST	~~~	NO	21136
	Sta Registr		31. Date filed (Month, Day, Year) FER 2 6	2009 32. Registra	ar's Signature	9. A	bonts					

State of Maryland / Department of Health and Mental Hygiene, State
Registra/AMEND#26perMD2-24-09, BMW, Moc Certificate of Death 3. Time of Death 2. Date of Death February 20, 2009 **Physician** ZELEDON GRANADOS 3:15A. м ALVARO D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Beltsville 12189 Beltsville Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 95 Costa Rica M 2□ F 218-76-3738 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County IOc. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Prince George's Beltsville Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 amp injury or other traumatic event, the Medical Examiner must be nonce. 20705 Guatemala 12189 Beltsville Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 ☐ No Specify Costa Rican Specify: White 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Produce Səlesmən 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jaime Zeledon Granados Joaquina ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12189 Beltsville Drive Beltsville, Maryland 20705 Ligia Flores -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State Metropolitan Crematory 2/23/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) DAUGHTER'S Other: 4 Nursing Home 5 Residence 6 Domer Sp Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 1 V Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier parisoner MO FEBRUARY 20 2009 Our D16619 30. Name and Press of person who completed cause of death (Item 23a) (Type, Print) CALVERTON, M.D. 20705 C. VERGARA - SOARES 4041 POWDERMILL RD 31. Date filed (Month, Day, Year) 22 Registrar's Signature State Registrar

09-01759	
lan Gray	

9-01/59	Please Type or Print in Black Indelil		Legible.
in Gray	·	ent of Health and Mental Hygiene	2009 0743
	1- For State Registrar Certifica	te of Death	Reg. No.
Physician		2. Date of	
ledical Examine	Ian Hunter Gray	Month March	2, 2009 Year 0650 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	8108 Gorman Avenue # 328	Laurel	Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs. 8. Date of	f Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	213-54-7307 1X M 2 F 53	Months Days Hours Min.	ary 28, 1957 Country) MD
	Usual Residence of Decedent	Yrs. Sariu	ary 20, 1997 commy, PhD
rue k	10a. State 10b. County 10c. City, Town of	r Location	10d. Inside City Limits
*		urel	1 X Yes 2 No
Maryland 28n-f show d at once	40- 00		
the Maryland a or 28a-f sh tified at onc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
uth the Maryland 23a or 28a-f sho notified at once		20707	USA
or items 22	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	
death or ite	1 Never Married 2 XXMarried 1 Yes 2 X No	ir res, specify Cubart, Mexican, 1 deric Modif, etc.,	varine, etc.
safter ral", o		1 Yes 2X No specify:	Specify: White
hours afte natural", Examiner		ecedent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
72 h 72 h 31 E	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retired)	
•0036 within 72 hour giene. her than "natu	3	Management	Hotel
15-0036 Iled within 77 Hygiene. I other than	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Midd	die, Maiden Surname)
21, be fill mral F rrked rrked	John Gray	Mary Hunte	r
Mer mar		Mailing Address (Street and Number or Rural Route	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 near of Fleath and Monthel Hygiens int: If item 27 is marked other than ' or other transmatic event, the Medical	Kimberly Kurilla-Gray / Wife 8	108 Gorman Ave. #328, Laurel, 1	MD 20707
e,	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, Date	20c. Location - City or Town, State
DOF Bees at of t: F	Telloval follotate	ry or other place) March 4, 20 litan Crematory	009 Alexandria, VA
Baltimore, permit Pages I at Department of Hee Important: If ite	4 Donation 5 Other Specify:	22. Name and Address of Facility	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera dother than "matural", or items 23a or 28a-f she important: If titem 7 is marked other than "matural", or items 23a or 28a-f she injury or other translatic event, the Medical Examiner must be notified at once To Be Completed by European Director	Drugu Filler	Francis J. Collins Funeral Ho 500 University Blvd. West, Si	ome Inc.
	23a. Part I. Enter the disease, or complications that caused the death. Do not		
Physician /Medical	failure. List only one cause on each line.	enter the mode of dying, such as cardiac of respiratory	Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive athe	rosclerotic cardiovascul	ar disease Death
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red Type Paraminer	cause Enter Underlying Cause (Disease or injury that injury)		
۵= ا ق	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
	X UNPENDED AMENDED 23a,P11,2/	perME, g889 3/11/09 TT	
J. Box 68760, the death certificate be. by the attending physicisched for use as the buriched for use	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
587 srtiffic fing p	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
OX (cath co	4 Pregnant at time of death 5	Other (Specify)	_
the de	1 Yes 2 No 9 Unknown g Unknown		
P.O. Es that the congression of			oid tobacco use contribute to the cause of death?
S, P.C lires that signed to d be deta	Chronic alcoholism		Yes 2 No 3 Probably 4 V Unknown
Records, I The law requires ficate has been sig page 2 should be		24a. V	Vas an 24b. Were autopsy findings available utopsy prior to completion of cause of
e law te has			erformed? death?
tal Rec		26.Place of Death (Check only one)	es 2 No 1 Yes 2 No
of Vital ng Physician: After this certi nneral director	examiner?	Other	Residence 6 ✓ Other: Scene
f Vif	1 ✓ Yes 2 No I inpatient 2 ER/OU 27. Manner of Death 28a. Date of Injury 28b. T	patient o some o	ibe how injury occurred
ding Ph	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	1 Yes 2 No	ibe now injury occurred
SiO Vittern deat ector	2 Accident Investigation		
Division tal or Attendir rs after death. at Director: A led in by the fu	Suicide 6 Could not be 288. Place of Injury - At home, far		on (Street and Number or Rural Route Number, City vn, State)
	4 Homicide determined (Specify)		
n 24 l	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat		` '
To the Total	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
Dla OS	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
To the Hosp within 24 hosp completely fi	luce	O.C.M.E.	March 2, 2009
	30. Name and address of person who completed cause of death (Item 23a)		
	Ana Rubio MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21201	

OCME

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 19 Month **Physician** Alice Loque Gesell 2009 9:10 pM February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Westminster Carroll Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 28 F 95 Aug 02 1913 Director 212-01-8673 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notifled at 1 TYes 2 No MD Carroll Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any hiury or other traumatic event, the Medical Examiner must be 1 21157 **USA** 134 Hollow Rock Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) English American Seamstress 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Spencer Carroll Loque 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Snyder/daughter 232 Bezold Avenue Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/24/2009 Westminster, MD Deer Park UMC Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Prints PeneralinHome and Chapel, P.A. 12 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Week **Physician** disease or condition resulting in death) /Medical as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical law requires that the death certificate If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use corribute to the cause of death? Records, 2 1 ☐ Yes 27 No 3 ☐ Probably 4 ☐ Unknown cate has been signal page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate Division or Vital Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 6 Other (Specify, 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After t y filled in by the funera After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D. 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

FEB 23

DHMH 17 Rev 1/2001

WIL

Street 4 Kestruster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

Box 68760.

P.O.

Division of Vital Records,

FEB 2 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month Enid W. Hopke /Medical Feb. 17 2009 1900 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Pay, Year) | 4 / 1 8 / 1 9 3 5 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X F 226-42-3102 73 Wash., D.C. Director Usual Residence of Decedent 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, the Widdeal Exar, it are must be notified at 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Germantown Director 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18003 Maten Road #205 20874 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ev Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. ò Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien-Important: If Item 27 is marked other tha any injury or other traumatic even-once. Claims Adjuster Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Russell Wall Enid Ruth Hogan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Hopke Bassin/daughter 13951 Penn Shop Road Mt.Airy, Md. 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 Removal from State Chesapeake Crem. 2/21/2009 4 ☐ Donation / 5 ☐ Other (Spegis Beltsville,Md 21. Signature PHILIP ADERINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic shock
Due to (or as a consequence of): 2wks /Medical Examiner Respiratory failure 2wks Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse uence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed? Hours after death. Clostridium difficile colitis 3wks Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical Pneumonia 1mo. the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2**X** No Month Day Year 5 ☐ Other (specify) the 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should Completed 1 □ Yes 2 □ No 3 Probably 4 💆 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 24a. Was an certificate 1 □Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D0066416 Feb. 18, 2009 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Month, Day, Y

31. Date filed

Sujatha Ramaseshan MD

32. Registrar's Signature

9901 Medical Center Dr. Rockville, Md 20953

State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb 18.2009 7:45pm м Hatanaka /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Montgomery Casey House Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April 1, 1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 **反** M 2 □ F Japan 486-44-4398 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire x7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Marties. 10d. Inside City Limits 10a. State 10c. City. Town or Location 1√ Yes 2 No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5503 Christy Dr 20816 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Japanese 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bureau Elementary/Secondary (0-12) College (1-4or 5+) Accountant Population Reference 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kamechiyo Hatanaka ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6824 Millwood Rd, Bethesda, MD 20817 Alan Gelb/ Friend 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Falls Church, VA National Crematory 2-24-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 Days Subdural Hematoma /Medical Due to (or as a consequence of): Examiner Sub Arachnoid Hemorrahage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Bascular Skull Fracture Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 24 No dea⊪? 1 ∐Yes 2 ⊠No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day, Year) Jan 31,2009 5:00p 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending Slip/Fall 1 □Yes 2 No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28f. Location (Street and Number or Rural Route Number, ģ 4 Homicide determined 5503 Christy Dr 20816 in 24 hour.

o the Funeral D'
completely fills Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Josetyne Kouertchou, ms DO0 63748 Feb 19,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Jocelyne Kouatchou, MD

31. Date filed (Month, Day, Year)

altimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Registrar's Signature

6001 Muncaster Mill Rd, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]18, 2009 **Physician** February 7:40A. Joanne Motyka Heller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House Montgomery Hospice 8. Date of Birth Dec. 24, 1942 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. Washington, DC 66 579-54-5542 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 United States 4709 Odell Road Funeral death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2XNo Specify: Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Industry Bartender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be (unk) Edna Bassi Motyka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tran Lisa R. Tyrrell -Daughter 1560 North Bluebird Lane Homestead, Florida 33035 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 2/20/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Retroperitoneal Sarcoma /Medical Due to (or as a consequence of): Examiner Enteric Fistula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐XNo Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kouetchou, ms 10063748 February 19, 2009 socettine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, Maryland 20855

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

24

32 Registrar's Signature

P.O. Box 68760, Division of Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed this eral Director: After th filled in by the funeral n 24 hours a

Certification: To

Medical

27. Manner of Death 1 ☑ Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title

State Registrar

my. D0055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sc Smte 310 Workington DC Palmen Mil 1326 Southern Kuhario avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature usua

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital:

5 Pending investigation

6 Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated

			For State Registrar	State of Maryla		artment of F rtificate of I			iene _{eg. No.} 2001	07443
	Physici	on	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physici /Medio		Joann		anson			Februar	y 18, 200	9 3:10P M
	Examin	er	4a. Facility Name (If not institution, give 100 Colony Crossir			4b. City, Town, or Edgewate	r Location of Death		4c. County of De	Arundel
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		158-24-7429 Usual Residence of Decedent	JM 2∰F 78	Yrs.	Nontris Days	Tiouis Iviii.	Mar. 30	,1930 Ne	Jersey
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Marriaga-f sk	Director	Maryland Anne Aru	ındel Edg	gewater					1 □Yes 2 🛣 No
	a or 28	Dire	10e. Street and Number			10f. Zip Code			0g. Citizen of What (Country?
	ms 23	Funeral	340 Hamlet Circle	12. Was Decedent Ever in U	J.S. 13. \	21037 Was Decedent of H	ispanic Origin? (Sp		JSA 14. Race - Ar	nerican Indian,
9	after or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1	I .	f Yes, specify Cuba 1 □ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	ite, etc.
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinat must be redified at	Completed by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:						hite
215	nin 72 r. "nat	plete	15. Decedent's Edu (Specify only highest grad	e completed)	i (Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	ing	16b. Kind of Busines	s/Industry
212	ed with	Com	Lieniemary/Secondary (0-12)	College (1-4or 5+)	Teach	ner			Education	
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last)	L			18. Mother's Name			
IT Y	should nd Me mark matic	10	Herman Teri 19a. Informant's Name/Relationship (Ty	nune	19b. Mailir	a Address (Street	France		Gager , City or Town, State	Zin Code)
ĭ,	and 2 salth an 127 is		Tammy Page/Daughte		1				MD. 21037	210 0000)
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting must be rectified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date 2	20c. Location - City of	r Town, State
ţim	it. Pag rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	La			dens 2/23		Davidsonv	
Ва	Depar Impo any Ir once		21. Signature of Funeral Service Licens		29	73 Solom	ons Islan	orge P. K d Rd. Ed	Calas Fune Igewater,M	ral Home D.21037
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
4	Physician //		Immediate Cause (Final disease or condition resulting in death)	Brain Cance		static f	rom Lung			Onset and Death 2 months
7	Examiner			Due to (or as a consecution Carcin						5 years
	P ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						J years
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	augusta of					
68760,	e be e sician s buria	Sal E		Due to (or as a conser	quence on.					
	rtificat ng phy as the	Medical I		J						
Вох	or Attending Physician: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3	Ectopic pregnancy	/		23d. Date of d	elivery Day Year
Ö	that the de ned by the	ysic	1 □Yes 2 No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)			World	Day Tear
ď.	s that gned b e deta		Part II. Other significant conditions cor	ntributing to death but not res	sulting in the ur	iderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
of Vital Records,	w requires that s been signed t should be deta	Completed by	Breast Ca	arcinoma				1 ½ Ye	s 2 No 3 1	Probably 4 Unknown
3ec	e law r has b	nple						24a. Was an	v prior to	autopsy findings available completion of cause of
la	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medical					perform 1 □ Yes 2		s 2 No
Z	yslcia is cert directo	To Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐	TER/Outpatien	t 3□ DOA Othe	26. Place of Death			Daughter's
n o	ding Ph h. After th funeral	T:no	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	/ at	28d. Describe how	w injury occurred	Touse
Division	Attendi death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	loo- Birra (Islanda		M 1□\	res 2 □No			
Div	al or A s after o	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, stre ify)	et, factory, office		281. Location (Str City or Town,	eet and Number or F , State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the ca	ause(s) and manner ate and place, and du	as stated. le to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and manner stated.	<u> </u>	29c. License	number	29	d. Date signed (Mor	th, Day, Year)
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	B 0 1		30. Name and address of person who co	manifestant course of do-th- (th-	m 23a) (Time F	Print\			1 1	
	NOW!					•			/	
	Stat	le .	Stephanie Trifog1 31. Date filed (Month, Day, Year)		O Green	•	er Drive	Greenbel	t, MD.207	70

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ARY Month Year NNIGAN 02 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 108 Colony Crossing Edgewater Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Year 1 □ M 2 🗷 F 579-44-2711 Yrs. 81 Director Sept. 10,1927 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits items 23a or 28a-f showner must be notified at Director New Jersey **Burlington** 1 ☐ Yes 2 No Mansfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Hilltop Lane East Funeral 08022 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or hany injury or other traumatic event, the Medical Exercisions 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: ģ Specify: USA 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Patton ည Sadie Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Mason/Daughter 108 Colony Crossing Edgewater, MD. 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem 3/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 2973 Solomons Island Rd., Edgewater, MD 21037 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an autopsy performed Yes 2 No certificate 1 🗆 Yes this certifical director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home} \) 1 Yes 2 No 1 Inpatient မှ 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) Accident investigation 1 □Yes 2 □No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

FEB 2 0 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 23^{Day} John Paul Huber 2009 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1212 St. Louis Ave. #273 Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6/10/1932 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F 231-36-8761 NY Director 76 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Experiment must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester 1X Yes 2 □ No Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 St. Louis Ave. #273 21842 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John D. Huber ဥ Marian Hartford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda Huber / daughter 303 S. Bay Dr., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 2/27/2009 Dagsboro, DE 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 00000 /Medical Due to (or as a consequence of): Examiner hen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached it ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □Yes 2 □ No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00

BA 10

State Registrar

31. Date filed (Month, Day, Year) FEB 27 2009



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

barker

			For State Registrar		State o	f Maryla	and / Depa <i>Ce</i>	artmen rtificat			and M	lental Hy	/giene Reg. No.	71111	9	07446
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and the	/Medic		ELLEN					T				02-	24-	200	9	19:40 AM
	Examir	ner	4a. Facility Name (If not in	-		,	- V 2-			Location	of Death		1	County of D いいい		Ch
	Funeral		5. Social Security Number	6. 8	Sex		rs. last birthday)	_If Under	1 Year	If Under		8. Date of Bi	rth		Birthpla	ace (State or Foreign
-	Director		230-54-3848		I □ M 2 □ X F	67	Yrs.	Months	Days	Hours	Min.	7/23/	1941		Countr	VA VA
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		2720 Braeburn Lane		Chesapeake Beach		Calvert	
Funeral		5. Social Security Number 6. Sex 7. Age (I	In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
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Te, Nand I and Health		20a. Method of Disposition	20b. Place of Disposit	tion (Name of cemetery.	Date	20c. Location - City or	Town, State
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Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Departanent of Mealth and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Mean and Mental the Mean and		The unature of Funeral Service Picensee	22. No	ame and Address of Facility Ra 325 Mt. Harmony	usch Fur	neral Home,	P.A.
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/Medical xaminer	9	failure. List ofly one cause on each line. Immediate Cause (Final disease a Atherosclerotic Ca	ardiovascular Dise	ease			Between Onset and Death
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical	(Check only one) 2 Wedical Examiner: On the basis of examin					
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		(& rulalo. nD		O.C.M.E.		February 20, 200	09
		30. Name and address of person who completed cause of deal		Charles Dell'er 120 212	104		
RW 7+1		Laron Locke MD. Assistant Medical Exam 31. Date filed (Month, Day, Year) 32. Registrar's		Street, Baltimore, MD 212	.U1		
St: Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's	orginature /	41 4			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** Mary Haggerty 2130 2009 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS Memorial Campus umberland 9. Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) May 5 1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min. 1□ M 2√2 Hours Months Davs 76 234-46-7005 Director Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it wheelest Examinar must be notified at MD Allegany Director Rawlings 1 ☐ Yes 🏋 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21557 21311 Burke Hill Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: white 1 ☐Yes 2 No Specify 2 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) School System Bus Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Wilt Charles Rounds 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra Gary A. Haggerty/son 21206 Powers St, McCoole, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If iter any Injury or oth once. 02/20/ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Keyser, West Virginia Potomac Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of tying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami for use as the burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☑ No 2 □№ 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, lospital or Attendin thours after death. uneral Director: Af ely filled in by the fur Hospital within 24 hours To the Funeral

death

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

es of person who completed cause of death (Item 23a) (Type, Print)

Zama Gamar 31. Date filed (Month, Day, Year) FEB 8

29a, Certifier

(Check only one)

Medical

5 Kent 32. Registrar's Signature

State Registrar

09-01569	
Faunteen Hai	rris

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner Month Day February 22, 2009 1943 hrs FAUNTEEN HARRIS 4a. Facility Name (if not institution, give street and number) c. County of Death 401 Montrose Avenue, Apartment E Prince George's **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreian Director Months Days Hours 579-58-8585 1³⊀ M 2 F 01-27-1948 Country) Wash., DC Usual Residence of Decedent iny 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f shor must be notified at once. Maryland|Prince George's Laurel 1- Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Montrose Avenue Apt.E 20707 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 - Never Married 2 White, etc. 1 ⅔ Yes If Yes, Give Year 1971 Widowed Divorced or other traumatic event, the Medical Examiner Yes 2 % No specify: If item 27 is marked other than "natural". Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 721 ment of Health and Mental Hygiene College (1-4 or 5+ Baltimore, MD 21215-0036 02 Transportation Operator Private Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Andrew A. Harris, II Hildegarde Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Weedamel H. Magruder/sister 11800 Birchview Ct. Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State crematory or other place) % Burial 2 Cremation 3 Removal from State portant: Maryland Vet.Cem. 03-02-2009 Cheltenham, Maryland Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Hypertensive atherosclerotic cardiovascular disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and tran Physician/Medical AMENDED 23a, PII, 27, permE, g889 3/11/09 TT X UNPENDED attending physician for use as the burial Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Month past 12 months Day Year Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Records, P. Renal disease on dialysis; Cocaine use; 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available Diabetes mellitus autopsy prior to completion of cause of certificate has performed? death? page ✓ Yes 2 1 🗸 25. Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) examiner? Hospital: Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes Residence 6 V Other: Scene After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural reral Director: filled in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2009 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Yea State istrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 07450 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay 20, **Physician** Joyce Heffernan Irons 2009 2:25 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 14313 Gaines Avenue Date of Birth (Month, Day, Year Oct. 30, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. 1□ M 2 T F Months Hours 1928 New York 133-20-5750 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 14313 Gaines Avenue 20853 USA 23a Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€3No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò White 1 □ Yes **X**XNo Specify: Specify: <u>۾</u> 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event in the Meany injury or other traumatic event injury or other event injury or othe College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Timothy Matthew Heffernan Catherine Marie O'Donnell ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Francis Joseph Irons/Husband 14313 Gaines Avenue, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 26 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd., W.. Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 months Physician Small-Cell Carcinoma of the Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ∐ Yes 2 🛣 No by the 9 Unknown 9 I Unknown been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed? certificate 1 ☐Yes 2 XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2∰No Other: 4 Nursing Home 5 Massidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident To the Funeral Director:

To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ၉ D02338 February 23, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard P. Delaney, MD 3929 Ferrara Drive, Wheaton, MD 20902 31. Date filed (Month, Day, Year) FEB 24 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2009 **Physician** February 10:30 Rhee Young Joo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Hours Days 52 FEB 29, 1956 Korea Director 334-74-0149 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinat must be notified at 1 □Yes 2 X No Director Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Korea 11801 Ambleside Drive 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🛛 No Specify: 2 Specify: 3 Widowed 4 Divorced Asian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th Self Employed Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be K Rhee Jung Kim Hae ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11801 Ambleside Drive, Potomac, MD 20854 Hea Rhee / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 02/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Mem. Park Olney, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility
Fairfax Memorial Funeral Home M00956 9902 Braddock Road, Fairfax, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE RESIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SEVERE SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner be executed SCLEROSING PERITONITIS burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 □Yes 2 **X**No 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of deptifier FEBRUARY 20, 2009 D63579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910 TAVAG, M.D. MARIA J. 3. Registrar's Signature 31. Date filed (Month. Day. Year) State 3 FEB Registrar

			For State of N		partment of Health a	and Mental Hy	giene Reg. No.2009 07452
	ysicia Medic		1. Decedent's Name (First, Middle, Last) Michael Earl	Johns	- · · · · · · · · · · · · · · · · · · ·	2. Date of De Month Februa	
	amin	er	4a. Facility Name (If not institution, give street and numbe 1430 Atwood Road	r)	4b. City, Town, or Location of Silver Spri	ng	4c. County of Death Montgomery
	eral ector		5. Social Security Number 579-58-3246 Cusual Residence of Decedent	age (In yrs. last birthday 64 Yrs.	/) If Under 1 Year If Under Months Days Hours	Min. (Month, Da	9. Birthplace (State or Foreign Country) Virginia
Maryland	iffed at	ctor	10a. State 10b. County Maryland Montgomery	10c. City, Town or L	ocation er Spring		10d. Inside City Limits 1 ☐ Yes 2 █️No
h with the 23a or 28	et be no	al Director	10e. Street and Number 1430 Atwood Road		10f. Zip Code 20906		10g. Citizen of What Country?
DallIIIIOTE, INIGITYIGITG 2.12.13-00.30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Evaruiner mu	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ If Yes, Give Year or Dates	No	. Was Decedent of Hispanic Orl If Yes, specify Cuban, Mexicar 1 □ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
xithin 72 ho lene.	he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give life.	edent's Usual Occupation e kind of work done during mosi DO NOT use retired) sultant	t of working	16b. Kind of Business/Industry
and and a diled be filed ental Hygics (ed other canal can	event, I	Be	17. Father's Name (First, Middle, Last) Earl Johns	Con		r's Name (First, Middle,	,
Maryl d 2 should th and Me	traumatic	၉	19a. Informant's Name/Relationship (Type. Print) Dora Ceballos Johns/Wife			er or Rural Route Numb	.a L. Lane er, City or Town, State, Zip Code) Spring, MD 20906
more, I	or other		20a. Method of Disposition PD Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disponentery, cre		Date Feb. 28,	20c. Location - City or Town, State
Dallillor permit. Pages Department of Important: If it	any injur		4 □ Donation 5 □ Other (Specify) 21. Signa ure of Fineral Service Licens		22. Name and Address of Facility Francis J. Col.		
Physic /Med Exami	ical		Due to (or as	ed the death. Do not en	nter the mode of dying, such as	Cardiac or respiratory a	rrest, Approximate interval Between Onset and Death years
cate be executed physician and	burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	s a consequence of):			
The law requires that the death certificat ate has been signed by the attending phy	for use as	Me		2 ☐ Fetal death 3 [□ Ectopic pregnancy		23d. Date of delivery Month Day Year
quires that	pe de	2	Part II. Other significant conditions contributing to death I	out not resulting in the u	underlying cause given in Part I.		obacco use contribute to the cause of death? 'es 2 XNo 3 Probably 4 Unknown
: The law re	page 2 sho	Completed		-		24a. Was autop perfor 1 🗆 Yes	sy prior to completion of cause of death?
Physician:	<u> </u>	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outpatie	Othor	of Death (Check only or	ne) lence 6 □Other (Specify)
or Attending after death.	tunera	Certification: 1	27. Manner of Death 13 Natural 5 Pending (Month, Di 2 Accident Investigation	ury 28b. Time o	of 28c. Injury at Work? M 1 Yes 2 N	28d. Describe h	ow injury occurred Street and Number or Rural Route Number
the Hospital hin 24 hours a	pletely fills	enical	29a. Certifier (Check only one) Certifying Physician: To the best and manner st and manner st	of examination and/or in	th occurred at the time, date and overstigation, in my opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the	Сош		29b. Signature and title of certifier July July 29b. Signature and title of certifier	~	29c. License number D3 28 6		Ped. Date signed (Month, Day, Year) February 23, 2009
			30. Name and address of person who completed cause of a Ari Fishman, MD 5530 W		Print) Venue, #1125, C	hevy Chase	MD 20815
Re	State gistra			rar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 3 per PHYS, G889, 3/11/09 WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death Reg. No. 3. Time of Death 18:08 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2009 Barbara Jean Jackson 02 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's General Hospital Cheverly 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. Months Hours 1 □ M 2 🖼 F 70 07/04/1938 578-50-8419 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County 1√2 Yes 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 Funeral 201 58th Street SE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Specify: Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 grade Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Walter Banks Helen Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 429 Oglethorpe St. NW Washington DC 20011 Willie_Jackson/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 102/23/2009 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th Street NW Washington DC 20011 Dave 23a. Part of ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Hypertensive Heart Disease anding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) detached 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2**X**No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 K Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D41405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Norman W. Allen, M.D.

State Registrar 1647 Benn... 31. Date filed (Month, Day, Year, FFB 24

1647 Benning Rd NE Apt. Year)

2009

Box 68760,

P.O.

Records,

Division of Vital

#201 Washington DC 20002

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Leroy 12:35 P M John Jones February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Julia Manor Nursing Home Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Month Day, Year) Mar. 13, 1929 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours Min. 79 Pennsylvania Director 217-28-1579 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "Motical Experiment resist be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 10717 Lynn Court 21795 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 □Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: \$ 3 ☐ Widowed 4X Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Auto Parts Manufacturer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Edward Jones Ida Hershey ပ Lula 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. William Jones - Son 8615 Castle Creek Court N. Richland Hills, TX 76180 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Feb. 28, 2009 Williamsport, Maryland 21. Synature of uneral So Osborned Advincertadity Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ma SST W disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner ON MISON if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed lanoma attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 X No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completely filled in by the funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 □ Yes 2 🗌 No 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 02-21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15H-4 Khalid Waseem, 1126 Opal Court 32. Rygistrar's Signature M.D. Hagerstown, Maryland 31. Date filed (Month, Day, Year) State FEB 27 Registrar

			For State Registrar		State of	i Marylar	nd / De	epartment of Certificate of	Health of Dea	ก and M <i>เth</i>	iental Hyç	giene 2 (Reg. No.	009	07	455
	Physicia /Medic		1. Decedent's Name	e (First, Middle, La:	_{ast)} Jose	e Lope	ez J	aneo			2. Date of Dea Month Februar	ath	200g	3. Time of 1:00	
) E	Examin uneral	iner	Manor (Care Silv	ver Spri	ing 7. Age (In yrs.	s. last birthe	4b. City, Town, Silv If Under 1 Yea Months Dav	ver Sp	tion of Death pring nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	4c. Count Mor th	nty of Death Intgame 9. Birth	nery nplace (State cuntry)	or Foreign
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ie Maryla	Ja-f show	Director		Montgam	nery	100. 01	ty, Town o	or Location Burton		le				10d. Inside Ci 1 1 Y Yes	City Limits s 2 ☐ No
ith with th	23a or 2e ust be no	ral Dire	10e. Street and Num	^{Imber} Strawberr	ry Lane			10f. Zip Code		0866	1	10g. Citizen of	of What Coul	ntry?	
5-0036 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	3 ☐ Widowed	ried 2 ☑ Married 4 ☐ Divorced	12. Was Decer Armed For 1 Yes If Yes, Give Year or Da	2 ⊠ No ve	J.S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ₩ No			cify Yes or No- Rican, etc.)	- 14. Ra Bla Specii	ace - Americ lack, White, cify: As:		
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Viand Z ould be filed wental Hygin	d othe event,	To Be Co	17. Father's Name (A					*100			e (First, Middle, I Dsalia P.	Maiden Surna	ame)		
Mar nd 2 sh alth and	item 27 is marke other traumatic	F	19a. Informant's Nar	lame/Relationship (7		ghter)	- 1	Mailing Address (Stree		umber or Rural	al Route Number	er, City or Town	n, State, Zip		
of High		5	20a. Method of Dispo	position ☐Cremation 3 🔀	Removal from S	20b. I	Place of Di cemetery,	Disposition (Name of crematory or other pl	place)	Da	Date	20c. Location	n - City or To	own, State	
permit. Pa	Important: I any injury o once.		21. Signature of Fun	5 ☐ Other (Specify uneral Service Licen		Mai		Memorial (22. Name and Additional)	dress of Fac	acility Reno	don/Hale	e Funer	ral Ho		Lippire
	edical miner		Immediate Cause (fi disease or condition resulting in death)	(Final	a. A Due to (o	or as a conseq	ath. Do not	ot enter the mode of dy	dying, such	h as cardiac or	or respiratory arre	rest,		Approximate Interval Bet Onset and D	etween
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the death certific	d for use a	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		ointh 2 ☐ Feta nant at time of d	tal death	3 ☐ Ectopic pregnan: 5 ☐ Other (specify)					Pate of delive		Year
law requires that	uld be deta	þ	Part II. Other signific	cant conditions or	ontributing to dea	ath but not res	ulting in th	the underlying cause g	jiven in Par	at I.		bacco use con es 2 No			
The law re	page 2 shor	Completed									24a. Was ar autops perform 1∐ Yes 2	med?	o. Were auto prior to cor death? 1 \(\text{Yes}	opsy findings a ompletion of ca 2 \(\sum \text{No} \)	available ause of
i Of VILO ig Physician ter this certifi	Affer this certificate has funeral director, page 2.	n: To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐ N 27. Manner of Death	No th	28a. Date of	of Injury	28b. Tim	me of 28c. Inju	Other: 4 💢 I	Nursing Hom	n (Check only one me 5 ☐ Reside 28d. Describe ho	ence 6 □Oth		fy)	
To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been stoned by the	d in by the fund	Certification:	1 ⊠Natural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 ☐ Pending investigation 6 ☐ Could not be determined	(Month,	th, Day Year)	Injui nome, farm,		Yes 2	2 □ No	28f. Location (Str City or Town	treet and Numb		al Route Num	ıber,
he Hospit in 24 hour he Funer	pletely fille	edical	29a. Certifier 1 (Check only 2 one)	1 X Certifying Phy 2 Medical Exam	nysician: To the b miner: On the bas and manne	asis of examina	owledge, d ation and/c	death occurred at the to	time, date y opinion, (and place, ardeath occurre	and due to the called at the time, d	ause(s) and m late and place	anner as si	tated. o the cause(s	à)
To the within	comp		29b. Signature and ti	title of certifier	som -				ense number	7874		29d. Date signe			,
24			30. Name and addres		completed cause	e of death (Item	n 23a) (Ty				ron .	2-2 MD 2	フ か フ・	2001	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TOHNSON Vear 45 AM **Physician** -eb maly 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore th WEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☐ M 2 🗶 F Months 80 579-38-5845 Director August 14,1928 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10a, State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evancian or must be notified at Director 1 X Yes 2 □ No District of Columbia Washington 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? death with 20011 5306 - 5th Street, N. W. United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No Specify 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health Care Workers d 2 should be filed within the and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 1 year Home Health Care Nurse of America 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Bill Livingston Willa Nelson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willanita Small Smith (Daughter) 809 Walnut Avenue: Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glenwood Cemetery March 2,2009 Washington,D.C. 21. Ignature, Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sersis disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner neumoluca Sequentially list conditions, if any, leading to immediate aude. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami and buriaf-tra Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year n signed by the a 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 100 ó 9 Unknown 9 ☐ Unknown σ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>გ</u> 1 Yes 2 No 3 Probably 4 Hinknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy performe certificate 1 □Yes 2 ☑ No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred or Attending Division (Month, Day, Year) Injury 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randallstown, MD 21133 5401 112h 31. Date filed (Month, Day, Year) State FEB 2 5 2009 Registrar

DHMH 17 Rev 1/2001

09-0131	15
Marvin .	Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	rtificate of	Death		Re	_{99. No.} 200	9 0143
Physici	an/	1. Decedent's Name (First, Middle,L	ast)				2. Date of Dea Month	Day Year	3. Time of Death
Medical Exam	iner	MARVIN JOHNS		·			February	14, 2009	0145 hrs
1		4a. Facility Name (if not institution, § 5102 Indian Head Highw		4	Oxon Hill	Location of Dea	th ·	4c. County of Dea Prince Georg	
						· Lieria a logia	10.5	th(MM/DD/YYYY) 9. B	
Funeral Director			Sex 7. Age (în yrs. l	ast birthday)	If Under 1 Year Months Days			Fore	ion Wach
Director		J17 11 0275	X ^M ² F 1	9 Yrs.			8/24/1	989 °	country)DC
~ ~~		Usual Residence of Decedent 10a. State 10b. County	Inc City	Town or Location	ın.				10d. Inside City Limits
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Marykand 28a-f show d at once.	tor	Maryland Prince (George's Bow	ie	10f. Zip Code		T	0g. Citizen of What Co	
th the Marykand 23a or 28a- f she notified at once	Director	Tue. Street and Number					l'	og. Chizen of What Co	unity :
ith the N 23a or notified		10620 Fitzgibbon	Court 12. Was Decedent Ever in U	0 40 18/2	2072		Specify Yes or No	United Sta	ites erican Indian, Black,
15-0036 Gled within 72 hours after death with the Maryland Hyggene. of other than "natural", or items 23a or 28a-f she is McMical Examiner must be notified at ance	neral	1 X Never Married 2 Marri	ed Armed Forces?		s, specify Cuban			White, etc.	encan indian, black,
er de ', or i	Fun		1 Yes 2 X No	1	Yes 2 _X No	specify:		Specify: B1a	-1-
136 hin 72 hours after e. than "natural", edical Ex. miner	b	15. Decedent's Education (Specify	or Dates:		s Usual Occupat		f work done	16b. Kind of Business	
2 hours	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life.	. DO NOT use re	etired)		- 12 12 12
336 thin 7 than edica	du	g		Labor	rer			Private	
5-0036 ited within 72 Hygiene. I other than '	S	17. Father's Name (First, Middle, La	st)	цаво		18.Mother's Nar	ne (First, Middle, I	Maiden Surname)	
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Be	Marvin Johnson	James Leon Ca	mpbell		Eileen	Johnson		
MD 21215-0036 of 2 should be filed within 7 fit and Mental Hygene. In 27 is marked other than umatic event, the Medical umatic event, the Medical	2	19a. Informant's Name/Relationship	(Type, Print) Father	19b. Mailing	Address (Stree	et and Number o	r Rural Route Nur	nber, City or Town, Sta	te, Zip Code)
nore, MD 2121. ages I and 2 should; be fill not of Heakh and Mental It: If ritem 27 is marked other traumatic event,		James Leon Campl	bell / Uncle					Maryland 2	
or Heah		20a. Method of Disposition 1 X Burial 2 Cremation		Place of Disposi crematory or oth		metery,	Date	20c. Location - City	or Town, State
Page:		4 Donation 5 Other Spec		ritage l	lemorial	2/	28/2009	Waldorf,	Marvland
Baltimore, permit, Pages I an Department of Hea Important: If ite injury or other tr.		21. Signature of Funeral Service La		22. N	me and Address	of Facility Po	pe Funer	al Homes,	P.A.
© 50 5 1	7.7	Aut a fa	W/n M 01085	55:	38 Marlb	oro Pik	e Forest	ville, Mar	yland 20747
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on	mplications that caused the death each line.	. Do not enter th	e mode of dying,	such as cardiad	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	8.74	Immediate Cause (Final disease	a. Multiple Gunshot Wour	nds		F 3-			Death
		or condition resulting in death)	Due to (or as a consequence of	of):					
	-a	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of	of):					
	i i	cause Enter Underlying Cause (Disease or injury that initiated	C						-94
ed sit	Examiner	events resulting in death) Last	Due to (or as a consequence of	of):					
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760, Trate be e	Medical							22d Date of delive	
876 tificat ng ph		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		al death 3	Ectopic preg	nancy	23d. Date of delive Month	Day Year
ox 687 eath certific attending for use as t	icia	past 12 months?	4 Pregnant at time of de	noth	er (Specify)				
Box le death c the atten	Physician	1 Yes 2 No 9 Unkno	a Cliniowii						
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to death but not r	esulting in the u	nderlying cause o	given in Part I.		obacco use contribute	robably 4 Unknown
S, P.C uires that n signed Id be deta	ed						-		autopsy findings available
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	Be	25. Was case referred to medical examiner?			26.Place	of Death (Chec	k only one)	•	
in of Vital Inding Physician: Inding the this certif Indine the control of the	입	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient			sing Home 5	Residence 6 🗸 Oth	ner: Scene
_ = ^ =		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Feb 14, 2009	28b. Time of Ir 0133 hrs		ry at Work?	Subject sho	how injury occurred	
ivisior or Attend after death Director:	atic	2 Accident Pending	ation			Yes 2 ✔ No			
Division pital or Attendiours after death neral Director: /	Certification:	3 Suicide 6 Could n		iome, farm, stree	t, factory, office b	building, etc.		Street and Number or I State) Head Highway, Oxor	Rural Route Number, City
Spita hours neeral		4 V Homicide determi	(Speed) Sidewalk						
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t	cal	Check only Certifying Phys	ician: To the best of my knowled ner: On the basis of examination a	ige, death occurr and/or investigati	ed at the time, da on, in my opinion	ate and place, a n. death occurre	nd due to the cau: d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
To t with To t	Medical	29b. Signature and title of certifie	and manner stated.		29c. Licens		-, -510	29d. Date signed (A	
	[[200, digitation dilla tale of deptille			O.C.			February 14, 20	
		- //	/ NS	- 220)	0.0.			. 55.55, 77, 2	
OCME		30. Name and address of person with Mary G. Ripple MD.	to completed cause of death (Item Deputy Chief Medical Exa		Penn Street	. Baltimore.	MD 21201		
1-2	tate	31. Date filed (Month, Day Year)	1		2 0000	.,,			
5	ાતાલ	FEB 2 5 2009 4	32. Registrar's Signat	Rad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Margaret Copeland Johnson Feb 19 2009 11:10 pM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2201 St Joan PLace Accokeek Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 F Days Hours Min 093-28-0633 73 18 1935 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's 1∰Yes 2□No Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 St Joan Place 20607 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X

If Yes, Give Black, White, etc. 1 ☐ Never Married 2 Married 2 🔀 No 1 ☐Yes 2 ☑ No Specify 3 Widowed 4 Divorced Specify: Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Postal Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Copeland Irene Thornton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Johnson/husband 2201 St Joan Place, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection Cemetery 2/25/2009 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) le tastatic months Due to (or as a consequence of): Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an performed 1 ☐Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation

Physician /Medical Examiner

permit. Pages Department of Important: If it any injury or o once.

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at

Completed by Funeral Director

Be

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit y physician and is the burial-trans attending pl this certificate has been signed by the all director, page 2 should be detached

Certification: To

Examine Physician/Medical Completed by Be

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Medical

Division of Vital Records, P.O. Box 68760,

Registrar

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oliver George Olive
31. Date flied Month, Day, Year)

6 Could not be

determined

MD PL 401

Broad

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P0066724

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2/23/09

Baltimore MD 21231

			For State Registrar		Maryland		artment tificate				lental Hy	giene Reg. No	111114	07459
	Physic	ian	1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	eath Da	y Year	3. Time of Death
	/Medi	cal	Robert		ennedy						Tebru	ay l.	0,2009	0817 M
	Exami	ner	4a. Facility Name (If not institution	£/		1	4b. City, T	own, or	Location o	of Death		-	County of Death	0
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. las	t hirthday)	If Under 1	Year	If Under	24 Hrs	8. Date of Bir		rince 6	evges
	Director		226 04 7271	1 ⅓ M 2□F	50	Yrs.		Days	Hours	Min.	(Month, Da	ay, Year)	Cour	
Are	pc ,		Usual Residence of Decedent								Jan :	20]	959 7	VA
	larylan show ed at	2	10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d. Inside City Limits
	the Mar 28a-f sh notified	Director	VA 10e. Street and Number			Norf								Profees 2 □ No
	with a or			-			10f. Zip C					10g. Citi	izen of What Coun	itry?
	ours after death with ral", or items 23a or Examiner must be	Funeral	3014 Racine	12. Was Deced	lent Ever in U.S.	13. V		509	spanic Orie	nin? (Sne	cify Yes or No		ISA 14. Race - Americ	an Indian
9	after o	Für	1 ☐ Never Married 2 ☐ Mar	Armed Ford	* *No					i, Puerto I	cify Yes or No Rican, etc.)		Black, White,	
93	ours r	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:	1	☐ Yes 2[ZINTO	Specify:				Specify:	Black
21215-0036	fled within 72 hours after death with the Maryland Hygiene. wther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Be Completed	15. Deceder (Specify only highe	t's Education st grade completed)	1	6a. Deced	ent's Usual kind of work OO NOT use	Occupation done du	tion uring most	t of workin	ng	16b. Ki	nd of Business/Inc	dustry
12	withir ene. than he Me	틽	Elementary/Secondary (0-12)	College (1-4	4or 5+)		kmase					c	onstruc	tion
d 2	e filed all Hygid other vent, th	ပ္	17. Father's Name (First, Middle,	Last)		DITC	Milas		18. Mothe	r's Name	(First, Middle,			
Maryland	2 should be f n and Mental H is marked of raumatic eve	To B	Bobby Frank	Kennedy									ourname)	
ary	shou and N s mai		19a. Informant's Name/Relations			19b. Mailin	g Address (5	Street ar	nd Numbe	or Aurai	Taylo	er, City o	r Town, State, Zip	Code)
Σ,	D ≢ 72 ± 1		Bobby F Ken	nedy/Fath	1		Rac						Va 2350	*
Baltimore,	yes 1 ar t of Hea if item or othe		20a. Method of Disposition 1 Disposition 2 ☐ Cremation	3 □ Removal from St	20b. Place ceme	e of Dispos etery, crem	sition (Name natory or oth	of er place)		ate		cation - City or To	
tim	E Pag tment tant: jury o		4 □ Donation 5 □ Other (5	pecify)	Roos		t Mer				1/09	Che	sapeake	, VA
Bal	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service	Licensee			Name and			11,1,1			ral Servi	
		0.0	23a. Part1. Enter the disease, or	complications that are	278						Norfo		VA 23513	
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Ath	r as a consequent	otic	_			1720			Distar	Approximate Interval Between Onset and Death
8760, 0	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence									
687	ficate phys s the	edical		d										
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 □ Fetal dea nt at time of death	ath 3□I	Ectopic preg Other (spec					2	3d. Date of deliver	ry Day Year
	w requires that the de been signed by the s should be detached t	2	Part II. Other significant condition	ons contributing to deat	th but not resulting	g in the und	derlying caus	se given	in Part I.				se contribute to the	e cause of death?
ecc	has be	Completed									24a. Was a		24b. Were autop	sy findings available
<u> </u>	The cate has page	E C									autop perfor 1□ Yes	med?	prior to com death? 1 □ Yes	pletion of cause of
Division or Vital Records, P.O. Box 68	sician: Th certificate rector, pag		25. Was case referred to medical examiner2					2	26. Place	of Death	(Check only or		10163	ELINO
Or.	Physi this c	P	1 res 2 No	Hospital: 1 ☐ Inp		Outpatient		Other:	4 LI Nur	sing Hom	e 5 🗆 Resid	ence 6	□Other (Specify))
n C	ding I	Certification:	27. Manner of Death 1 ■ Natural 5 □ Pendin		Injury 28t Day Year)	o. Time of Injury		. Injury a Work?			Bd. Describe h	ow injury	occurred	
isi	Attender death ctor:	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	injury - At home,	farm stree	M		es 2∐N	-	06 1 10 10			
ο̈́	after after Dire d in b	erii	4 ☐ Homicide determ	ned building	, etc. (Specify)	iaiii, stiet	et, ractory, o	шсе		28	City or Tow	treet and n, State)	Number or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	Medical C	29a. Certifier (Check only one) 1 ☐ Certifyin 2 ☐ Medical	g Physician: To the be Examiner: On the basi and manner	s of examination	lge, death and/or inve	occurred at testigation, in	the time my opir	, date and	l place, ar	nd due to the o	ause(s)	and manner as sta place, and due to	ated. the cause(s)
	Vithi To t	Ž	29b. Signature and title of certifier	. 1			29c. Li	icense n	umber		2	29d. Date	signed (Month, D	Pay, Year)
	2		Salvade	Blook) Do			Hoo	55	72) /	Estr	way 11.	2009
_			30. Name and address of person SALVALOR SUL	who completed cause of	of death (Item 23a	a) (Type, P	rint)	Dri	re,	CL	ever	, /	yorla	ind
	Sta Registra		B1. Date filed (Month; Day, Year) FEB 23	2009 33 Regi	istrar's Signature	par					01			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#7perFH2/24/09, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 5:41AM LEB 2009 Frances KRESS /Medical 4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington 4b. City, Town, or Location of Death Rockville 4c. County of Death **Examiner** Montgomery 8. Date of Birth 9. Birthplace (State March 15, 1917 New York 5. Social Security Number 102-07-8739 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 92 91 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examiner must be notified at once. 10b. County Montgomery Oc. City, Town or Location Rockville 10a. State MD 10d. Inside City Limits Director 1 □YYes 2 □ No 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number 6105 Montrose Rd., #3123 20852 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Midowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Nierenstein Anna Friedlander ၉ 19a. Informant's Name/Relationship (Type, Print)
June Kress / daughter 19b Mailing Address (Street and Number or Fural Boute Number, City or Town, State, Zip Code)
3900 W St., NW, Washington, DC 20007 Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

ADposition 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Zion at Hillside Cem 2/27/09 20a. Method of Disposition 20c. Location - City or Town, State Lyndhurst, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of FV er S rvice Ligense 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence or Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ERLIPIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown Completed YPOTHYROLD 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy DIFF 1 ☐ Yes 2 🔀 No OLITIS 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

29a. Certifier

Koran

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORZAN 1801

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Soon Ja Kim February 2009 4:55 pM /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner 4c. County of Death Silver Spring 201 Northwest Terrace Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🗵 F 85 Director 218-66-9201 December 19,1923 Republic of Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 □ No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3 201 Northwest Terrace 20901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify ğ Specify 3 X Widowed 4 ☐ Divorced 'natural", Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic event, Iteal once. Homemaker Domestic Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Rev. Won Min Lee Won Mo Hahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lina Kim - Daughter 201 Northwest Terrace, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 02/28/2009 Brentwood, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 17 Years Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and burial-trar Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Month Day Year 5 Other (specify) the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 🖾 No 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month. Dav. Year) D54378 February 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chery 1 ...,
31. Date filed (Month, Day, Year Cheryl Aylesworth, M.D. 2730 University Blvd. W., Suite 400, Wheaton, Maryland 20902 Year) Registrar's Signat State Registrar

Amend Item 5 per F.D. 02/23/2009 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 19 2009 12:48 p^M February Robert G. Kelvey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 807 Boxcar Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 04 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) F38LS22115576 **Funeral** Days 1**⊠** M 2□ F 136 22 5676 80 N.T Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Carroll Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 807 Boxcar Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WII 1 ☐ Yes 2 ☑ No Specify: ģ White 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mid-Atlantic Elementary/Secondary (0-12) College (1-4or 5+) Petroleum Corp President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harriett Smith ပ Granville Kelvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 807 Boxcar Drive Westminster, MD Sherry Allen/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/2372009 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signatur / Fungrat Service Licensee Britts Fune and Chapel, P.A. and 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WPD Immediate Cause (Final disease or condition resulting in death) **Physician** 6monte /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

WJZ

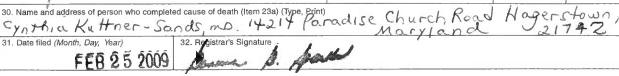
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 2

State

31. Date filed (Month, Day, Year)



Cynthia Kuttrez - Vando, 100

DHMH 17 Rev 1/2001

Registrar

tebruary 23, 2009

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			Registrar Decedent's Name (First, Middle, Last	st)	, .	-		2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic		TRA	K	ILMOR	1 11	T	02	21 2	2009	15:54 PM	
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death	un	4c. County	of Death		
	Funeral		5. Social Security Number 6. S	□	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 09-10-	h (, Year)	Countr	ice (State or Foreign	
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	ryland how		10a. State 10b. County		10c. City, Town or	Location			· · · · <u>-</u>	100	d. Inside City Limits	
	he Ma 28a-f s	Director	MD Calvert	<u>: </u>		Huntin	gtown		10- 014	VI 1 C 1	1 ☐ Yes 2 🙀 No	
	aa or 3		10e. Street and Number 1265 Brown Fox Dr	rive		10f. Zip Code 2063	10		10g. Citizen of V USA	mat Country	y :	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1	3. Was Decedent of H		ecify Yes or No- Rican, etc.)		e - Americar		
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2-00	72 hour	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. De	cedent's Usual Occup	pation	ring	16b. Kind of Bu	whit usiness/Indu		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show sht, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ve kind of work done . DO NOT use retire hanical En		ang	Federa:	1 Cour	mont	
ر م	filed v I Hygie other I	Be Co	17. Father's Name (First, Middle, Last)		nec	ialiteat El	18. Mother's Nam	e (First, Middle,			eriment	
ylan	Menta Menta arked atic ev	To B	Ira Ellsworth R	Kilmon, Jr			Edna	Taylor	McCra	у		
Mar	th and 7 Is mu		19a. Informant's Name/Relationship (1	iling Address (Street			-	State, Zip C	Code)	
ē,	s 1 and f Heali item 2 other		Joan D. Kilmon, s	spouse		Box 214, position (Name of rematory or other place		Date MD	20639 20c. Location -	City or Tow	n, State	
<u>=</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	itan Crem		5/2009	Alexand	lria,	VA	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hodical Expriner must be notified at once.		21. Signature of Funeral Service Licen	See Oro	_	22. Name and Address 8325 Mt.	I.C.	usch Fur ane. Owi		,		
			23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the cause on each fine	he death. Do not e					A Is	Approximate nterval Between	
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89 x			IF FEMALE:	One If we autoeme of	f =reanener							
Вох	ires that the death certific signed by the attending pl is be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Э У		23d. Dat Mo	te of delivery onth D	y Day Year	
P.O.	at the c by the tachec	hysi	9 🗆 Unknown	9 ☐ Unknown								
ds,	signed	5	Part II. Other significant conditions of		not resulting in the	_	en in Part I.				cause of death?	
COL	w requir s been s should	letec	Atrial Fibrithe	,	<i>FC</i>			24a. Was a			sy findings available	
æ	The law ate has bage 2 s	Completed		perfor	autopsy prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No							
Vita	Iclan: certific ector, I	Be	25. Ws case referred to medical examiner?	Hospital:		Low	26. Place of Dea					
of	Phys er this eral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,	t 2 ☐ ER/Outpat 28b. Time Year) Injur	of 28c. Inju		e 5 Residence 6 Other (Specify) 3d. Describe how injury occurred				
ion	anding rath. or: Afte	atio	1 Natural 5 ☐ Pending investigation	k? Yes 2 □No								
Division of Vital Records,	al or Atta	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Numb in, State)	er or Rural I	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use it	Medical C	29a. Certifier 1X Certifying Ph	ysician: To the best of niner: On the basis of and manner state	examination and/or	eath occurred at the to	me, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) and madate and place, a	anner as sta and due to t	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	- 2	29d. Date signed	i (Month, Da	ay, Year)					
			10- S. Oc	Roy MO		NPI	15/8/26	7/3 1	Feburary	22 **	2009	
ARV	12+1		30. Name and address of person who		ath (Item 23a) (Typ		ST Bal	Tima A.S	.A. D	7.17/	/	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signature	day of	· · · · ·	· · · · · · · · · · · · · · · · · · ·			/	
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Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
Amend Item 23a per phys. G890 4/21/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 21, 2009 **Physician** 11:35 AM Irwin Aloysious Kimmel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 87 04-25-1921 Washington, DC 577-12-0357 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director Calvert MD St. Leonard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20685 6594 Long Beach Drive United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐**X**No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacture Representative Commercial Construction permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Kimmel Margaret Schott ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia K. Jensen (Daughter) 6594 Long Beach Drive, St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/28/09 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 545 P. O. Box 600, Lusby, Maryland 20657 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner days Septicemia of Unknown Origin Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 18 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has The certificate 1□ Yes 2□ No Division or Vital Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) examme 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Attending 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. al or Attend after death filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number sunscul 167647 Iram A. Khan, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 5 2009 Marks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 8:25^p M February Melva Celestine Lahey 18, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 2, 6. Sex Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Year) 20 312-16-1243 1 □ M 2 🙀 F 88 Yrs. Indiana **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Twes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20877 333 Russell Avenue USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No δ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed th and Mental Hygiene.
7 is marked other than "natur: traumatic event, the Medical if 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Kenneth Edward Maynard Anna Marie Jones မ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15145 Winesap Drive, Gaithersburg, MD 20878 19a Informant's Name/Relationship *(Type, Print)* Diane Lindsell/Daughter Health am 27 i other 1 If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Feb. 20, permit. Page Department of Important: If any injury or once. Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licensee 500 University Blvd. W. Silver Spring, MD 20901 23a. Pirt1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Cardiac Failure /Medical Due to (or as a consequence of): Examiner Urosesis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Urinary Tract Infection attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Urethral Obstruction IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 K No cate has been signed by the page 2 should be detached in o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2**X X**No 1 □ Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐xNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death spital or Attending Piours after death.
neral Director: After 1
y filled in by the funers 28d. Describe how injury occurred Division 5 Pending investigation 1x Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital *XX-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only To the within 2 and manner stated 29b. Signature and tyle of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bernard Rogus, MD 3801 International Drive, #205, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 82. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O

requires that the death certificate be executed by the attending physician and control be detached for use as the buria-transit of control by Physician/Medical Examiner To Be Completed by Funeral Director Tequires that the death with the Maryland control be filed within 72 hours after death with the Maryland control begat the detached for use as the buria-transit control begat the marked other traumatic event, the Maryland control begat the maryland control begat the marked other traumatic event, the Maryland control begat the	4a. Facility Name Su 5. Social Security 578~05- Usual Residence 10a. State Mary1and 10e. Street and N 251 11. Marital Status 1 Never Ma 3 Widowed (Sp Elementary/Sec 12 17. Father's Nam 19a. Informant's Fr 20a. Method of D 1 Burial 4 Donation 21. Signature of I 23a. Part 1. Entershock or I	Aburban Hosp Number 6. 4858 of Decedent 10b. County Montg Number 1 Spencer R Sarried 2 Married 4 Divorced 15. Decedent's Enecify only highest gr condary (0-12) be (First, Middle, Las. Max Lopati Name/Relationship reda Resnick	Acond Sex	ge (In yrs. Ie 91 10c. City Ever in U.S. No WWII	16a. Deceding the life. D	If Under 1 Ye Months Da ation 10f. Zip Cod (as Decedent Yes, specify Code of Work & Code of W	Silver Spr de 20910 of Hispanic Origin? Cuban, Mexican, Pu No Specify: ccupation one during most of witired) Locksmith	Irs. 8. Date of B (Month, I Decembe	40 irth Year 7 31, 10g. C	Mont y Sirt Cot 1917 Distr itizen of What Cot U.S. 14. Race - Amer Black, White Specify: (Cot (Cot (Cot (Cot (Cot (Cot (Cot (Co	agomery Inplace (State or Foreignity) Ict of Columb 10d. Inside City Limits 1 □ Yes 2 ☒ Nountry? A. Ican Indian, etc. Caucasian Industry	
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Physician: The ratis certificate hard director, page: To Be Com								6 ☐ Other (Spec	ify)			
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Attending or death. ector: After by the fune ification	2 Accident	investigatio					I □Yes 2 □No					
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s. Medical Certification: To Be Compl	29a. Certifier (Check only	2☐ Medical Exa	Physician: To the best aminer: On the basis of and manner st	of examinati	reage, death on and/or inve	occurred at the estigation, in n	ny opinion, death of	ace, and due to the courred at the time	e cause(, date ar	s) and manner as id place, and due t	stated. o the cause(s)	
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1	one)		X				200100					
	29b. Signature and 30. Name and add	nd title of certifier	completed cause of c	leath (Item	23a) (Type, P	rint)						
State Registrar	29b. Signature and 30. Name and add	nd title of certifier	ZUZAK,	mo,	23a) (Type, P	Sus	سردهیس	HOSPITAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPH 0809 Ам 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) People's **Funeral** 1⊠M 2□ F People's 73 Yrs. Director May 10, 1935 216-36-2701 Republic of China Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, "14 Medical Exeminar must be notified at Director 1 ☐ Yes 2K No Laurel Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7910 Anfred Drive 20723 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify <u></u> 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Graphic Illustrator Technical Magazine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Teang Lew Sue Mark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Lew - Spouse 7910 Anfred Drive, Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 02/27/2009 Silver Spring 21. Signature of Funeral Sirvice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LABETES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed PERTENSION Exami sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes a No 1 🗌 Inpatient ၉ 2 KER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Iniury To the Hospital or Attendia
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Edward J. Lee, M.D., 11065 Little Patuxent Parkway, Columbia, Maryland 21044</u> 31. Date filed (Month, Day, Year) egistrar's Signature 32. State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene 1 1 1

		Í	For State Registrar			State of	Marylar		artmen rtificat				Mental Hy	Reg. No.	009	07469
4	Physici	an	1. Decedent's Name (Amildred P			inœr							2. Date of D Month Feb.	eath Day 26	200°	3. Time of Death 2:00 P
	/Medic Examir	40	4a. Facility Name (If no				oer)		4b. City,	Town, or	Location	of Death	reb.		County of D	
	Examili	iei	Coffman N						На	gers	town			I	Washir	ngton
	Funeral		5. Social Security Num		5. Sex	7. 4 2 K) F		last birthday Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Year)	9.	Birthplace (State or Foreig Country)
$\bar{\kappa}$	Director		215-14-14 Usual Residence of De				85	115.					Mar. 1	3, 19	923	MD
	yland		10a. State 1	0b. County				ty, Town or L								10d. Inside City Limits
	Ba-f s	ctor		Washir	igto	n 		Hagers								1 ☐ Yes 2X No
	th with the	al Dire	13157 Kai		dge	Road			1 0f. Zip	1740) 			US. Citi	zen of Wha	t Country?
21215-0036	Department of Health and Abrold be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Mardical Exert and time 12 to confiled at Decision.	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 🏿 Widowed 4 [. Was Deced Armed Forc 1 □ Yes 2 If Yes, Give Year or Date	es? ŒNo	J.S. 13.	Was Deced If Yes, spec		ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	Black, V	American Indian, Vhite, etc. White
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121	within ane. then "	Completed	Elementary/Second	ary (0-12)		College (1-4	lor 5+)		ssemb)			Mai	nufaci	turing
	ould be fited with Mental Hygiene. arked other than atic event, than	To Be Co	17. Father's Name (Fit Arthur Le	rst, Middle, L		n							e (First, Middle Pear1	e, Maiden	Sumame)	2012
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	t Health tem 27 other tr		20a. Method of Dispos				20b. I	Place of Disp	osition (Nar	ne of			Date			y or Town, State
m0	Pages nent of int: If II		1 🔀 Burial 2 🗀 (4 🗆 Donation 5			moval from St	are		-			03/0	2/2009	Hage	erstov	vn, MD
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Fune	ral Service L	icensee		Z	2								Funeral Home , ND 21740
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the shock, or heart fi Immediate Cause (Fir disease or condition resulting in death) Sequentially list cond if any, leading to immeause. Enter Underly Cause (Disease or in that initiated events resulting in death) Las.	ailure. List on al lis	a. b.	Due to (or	th line.	Quence of):	rter the mod	He Upe	g, such as		or respiratory			Approximate Interval Between Onset and Death
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rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significa	ant condition	ns contr	nbuting to dea	th but not re	sulting in the	underlying c	ause givi	en in Part I	i.				te to the cause of death? Probably 4 (SUnknown
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Vital	Physicien: this certific ral director,	To Be	25. Was case referred examiner? 1 Tes 2 Tes		Но	spital: 1 🗌 Inj	nationt 2] ER/Outpatie	ent 3 🗆 DC	Oth			th <i>Ch</i> eck only ome 5□Res	- 0.0	6 MOther (Snaciful
οt			27. Manner of Death			28a. Date of (Month)		28b. Time Injury		8c. Injun		J. 5	28d. Describe			opeony)
sior	Attending r death. sctor: After y the fune	catlo	2 Accident	5 ☐ Pending investig	ation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,	,,	М		Yes 2□	No				
Division	tel or Att rs after d al Direct ed in by I	Certification:	3 Suicide 4 Homicide	6 Could n determi	ned	28e. Place of building	of Injury - At h g, etc. (Speci	nome, farm, s	treet, factor	, office				(Street an own, State		or Rural Route Number,
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier N (Check only 2 one)	Çertifying ☐ Medical E	Physic xamine	cian: To the ber: On the bas and manne	is of examin	owledge, dea ation and/or i	th occurred nvestigation	at the tin , in my o	ne, date ar pinion, dea	nd place ath occu	, and due to the rred at the time	e cause(s) e, date and	and manne I place, and	er as stated. due to the cause(s)
	To ti To ti comp	W	29b. Signature and tit	le of certifier			2		290		number	23	23		-	Month, Day, Year) 5-2009
0	54-C		30. Name and addres Khalid M.	s of person v Waseen	who com	npleted cause	of death (Ite al Cou	m 23a) (Type	n Print) agerst	own,	MD 2	2174	0			
)	7	ate rar	31. Date filed (Month		-	32. Re	Istrar's Sign						2			
DH	IMH 17 Rev 1/2					-		10.								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:00 am 2009 February Florence Mintz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Hebrew Home Rockville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 87 June 09, 1921 New Jersey 140-18-9201 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show If is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at 1 ☐Yes 2 KINo Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20852 U.S.A. 6121 Montrose Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Its Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ၉ Joseph Gottfried Rose Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 81 Grand Avenue, #1E, Englewood, New Jersey 07631-3571 Edward Mintz - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/20/2009 Mt. Lebanon Cemetery Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.

1200 Note Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month in the past 12 months? Year 5 Other (specify) n signed by the a Id be detached fo ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ No 3 Probably 4 Unknown 1 □ Yes should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 5 autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3⊞No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 □Yes 2 □ No neral Director: A 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State 23 2009 Registrar

			Amended Items 2 & 23a, Part wj1 Please Type or Prin	I, Line c t in Black Inc	, per Ph delible lnk.	y. 02/24/2 Ensure All	2009 Ca Copies	rroll Co. Are Legible.	
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	Physicia	» an	1. Decedent's Name (First, Middle, Last)	· 4_			Februa		3. Time of Death
E#	/Medic Examin	_	Margaret L. Mot 4a. Facility Name (If not institution, give street and number) Preasant view Nursir	19 Home	4b. Cify, Town, o	r Location of Death	·	4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		hplace (State or Foreign untry)
Ľ	Director		504-12-1783 1□ M 21 F 8	5 Yrs.	Monato Baye	1	9/12/1923		
	Maryland f show led at	or	10a. State 10b. County MD Carroll	Mount Air					10d. Inside City Limits 1 □Yes 2 ¬No
	ith the lor 28a- be notifi	Funeral Director	10e. Street and Number	Toute The	10f. Zip Code 21771		1	Og. Citizen of What Co	
	death w	neral	4101 Old National Pike 11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13. V		lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	rican Indian,
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at ance.	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ N 3 ☑ Widowed 4 □ Divorced Year or Dates:	□ 1943 - 1 1946	1 □ Yes 2 1 No	Specify:	,,	Specify: Whi	
215-0036	in 72 hoi "natur ledical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of working d)	g	16b. Kind of Business/	Industry
2	filed withi Hygiene. other than		Elementary/Secondary (0-12) College (1-4or 5-2) 17. Father's Name (First, Middle, Last)	Cle	rk	18. Mother's Name	/Eiret Middle	US Post Offi	ce
land	should be fi and Mental H s marked otl umatic ever	To Be	George McNamara			Florence McI		walden Gumame)	
Maryland	2 shou and M Is mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street	and Number or Rural	Route Numbe	r, City or Town, State, 2	Zip Code)
-	1 and 2 Health em 27 l		Christine Frick(Daughter) 20a. Method of Disposition	20b. Place of Disponentery, crem	eafy Hollow sition (Name of	v Circle Mt.	Airy, M	21771 20c. Location - City or	Town, State
mor	Pages nent of I int: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	s. Carroll		^{ce)} 2/20/200	79	Winfield, Md	
Baltimore	permit. Pages Department of Important: If It any Injury or conce.		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ess of FacilitBurrie	er-Queen	Funeral Home	ľ
		\vdash	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin			Liberty Rd. V			Approximate
	Physician		Immediate Cause (Final disease or condition	SFPSI	S				Interval Between Onset and Death
7	/Medical Examiner		resulting in death) Due to (or as a	a consequence of):	nonia	· L			Plans
	d #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):	Debility	due to Pne	umonia	Aspiration	1 1
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P.0	that the ed by th detache	Phys	9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but	ut not resulting in the un	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Division or Vital	r Attend er death. rector: /	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju	ury - At home, farm, str c. (Specify)		Yes 2□No	8f. Location (S City or Tow	Street and Number or Ri In, State)	ural Route Number,
	spital o nours aft neral Di / filled in	al Cer	29a. Certifier Physician: To the best of	of my knowledge, deat	th occurred at the t	ime, date and place, a	and due to the	cause(s) and manner as	s stated.
	thin 24 h	Medical	(Check only one) Medical Examiner: On the basis of and manner sta	examination and/or in	29. Licens	opinion, death occurre		date and place, and due 29d. Date signed (Mone	+
	Mar		Melin tolk Kills	_O- Y > V	002	000	00	2/19	109
	4		30. Name and address of person who completed cause of de	eath (Itent 33a) (Type,	olds	note	lis bla	1 2111C	NJ 2104
ł	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registre FEB 24 2009 Since	sk's Signature	bares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 21, 2009 Physician Addie P. Morfoot 11:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll County Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year) 102 218-40-1967 19 Feb. 1907 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show ral", or items 23a or 28a-f shov Baltimore County 1 ∏Yes 2 XÎNo Maryland Upperco Director the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21155 3405 Mount Carmel Road United States Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White 2 3 X Widowed 4 □ Divorced and 2 should be filed within 72 hou saith and Mental Hygiene.

1.27 is marked other than "natural or traumatic event, in Medical E. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 8 17. Father's Name (First, Middle, Last) George Wilhelm 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any injury or other traumatic event 2008. Be Ida Hale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upperco, Maryland 21155 Patsy Morfoot Woolridge-daughter 3405 Mount Carmel Road 20b. Place of Disposition (Name of cemetery, crematory or other n 20c. Location - City or Town, State 20a. Method of Disposition Date 25, 1 XBurial 2 Cremation 3 Removal from State Forest Ridge Cemetery Upperco, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the de. th certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the allending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 menths? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) Division of Vital Records, P.O. □Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy perform 1 □ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b, Signatu

e and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 South Cauter

1.5

29d. Date signed (Month, Day, Year)

restmissor, MD 21157

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** George Andrew Mueller epryany /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 92 11 M 2 □ F 216-05-3449 7/19/1916 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Maryland Exercise must be notified at 1 □ Yes 🙀 No Director Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 1724 Baldwin Drive 21108 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ₩Xº WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√√No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lineman C&P Telephone 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>Gertrude Mueller Fisher</u> ပ Mueller Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Mueller Spouse 1724 Baldwin Dr. Millersville, MD 21108 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields 2/21/2009 | Millersville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Superal Pervice Licenses alan Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, and the Limme data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FFMA! F: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 2D 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27 Manner of De th 28h. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. veral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1xx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Dav Year 9:30 AM MONSINI RICHARD BERNARD February 18, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12 South Walnut Street Hagerstown Washington 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 50 219-72-2431 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Y⊒Yes 2 □ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U.S.A. 12 South Walnut Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Tire Company 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillev Margaret Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony W. Monsini Son 8303 Edgewood Church Road, Frederick, Md. 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Crematory 02-19-09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. R. hoel. 40 East Antietam Street, hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYCCARDIAL INFARCTION HOURS Due to (or as a consequence of): COROLARY ACTEDY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): YEARS TYTE 2 DIABETES MELLITUS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERUFIDEWIA 1 Yes 2 No 3 Probably 4 Unknown TOBACCO 4 PUSE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the M-di-al Examiner must be notified at once.

Maryland 21215-0036

Examiner Physician/Medical

Completed

2

Certification:

Medical

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

the death certificate be executed and attending physician for use as the buria icate has been si; ; page 2 should b certificate To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Division or Vital

Records, P.O. Box 68760,

15Hb-1

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 E. Antietam St.

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) FEB 2 0 2009

6 ☐ Could not be

Suite 203 Hagerstown 32. Registrar's Signature

GW.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D58810

and

2(740)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TEBRUARY

29d. Date signed (Month, Day, Year)

19 2009

			1- For State of Maryland / Dep State of Maryland / Co	partment of Hea			iene eg. No. 200	9 07475
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deal		3. Time of Death
	/Media		Marie E. Mazzone				26 09	7:45A M
	Examir	er	4a. Facility Name (If not institution, give street and number) Moran Manor Nursing Home	4b. City, Town, or Lo			4c. County of De	
مينون د	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Western Western If Under 1 Year If	port TUnder 24 Hrs.	8. Date of Birth	Alleg	• irthplace (State or Foreign
	Director		214-30-7559 ^{1□M 2} ♥F 95 Yrs.		Hours Min.	8. Date of Birth (Month, Day, 10 – 1 -	-1913 M	Country)
	p.		Usual Residence of Decedent				(1)	
	anylau show	'n	10a. State 10b. County 10c. City, Town or I Md Alleg Luke	Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M 28a-f iotifie	Funeral Director	10e. Street and Number	10f. Zip Code			On Cikings of Miles C	Δ
	with with the r	- Dir	331 Pratt St.	21540		'	0g. Citizen of What C	Southery ?
	death ms 2%	nera		3. Was Decedent of Hispa If Yes, specity Cuban, N	anic Origin? (Spec	cify Yes or No-	USA 14. Race - Am	nerican Indian,
9	after or ite	Fur	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give X	**			Black, Wh	ite, etc.
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	To B	Alfredo Diaz		Josp	hine A	lverez	
lan	2 sho and h Is ma auma		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	iling Address (Street and	Number or Rural	Route Number	, City or Town, State,	Zip Code)
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or injury					
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Box 6	th cer endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the proof to month? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy			23d. Date of de	elivery
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ta	an:] tificat tor, pa	Be C	25. Was case referred to medical	26	6. Place of Death			s 2□No
<u> </u>	nysici lis cer direc	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie				nce 6 □Other (Sp	ecify)
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Division or Vital	or Atlanta	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, s	street, factory, office	28	If. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
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	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	investigation, in my opinio	on, death occurre	d at the time, da	ate and place, and du	ue to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Ĭ	29b. Signature and title of certifier	29c. License nu	mber	29	d. Date signed (Mon	ith, Day, Year)
)				9212	44	6	2/27/20	009
		1	30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)			7 - 1	
	Sta	1	Jesus H. Tan 4 Broadway Fr 31. Date filed (Month, Day, Year) 32. Registrar's Signature,	ostburg,	MD 215	32		
	Sta Registr		FFB 27 2009 June B. A	barker				
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment of H <i>rtificate of E</i>		lental Hygi ®	ene g. No. 200	9 07476
ı	Physicia		1. Decedent's Name <i>(First, Middle, L</i> asi Belva Louis		Kenzie			2. Date of Death Month February	n Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	,		4b. City, Town, or Wester		- 0.01 0.01	4c. County of De	ath
- ²	Funeral Director		Social Security Number 6. Se		In yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 5	9.8	irthplace (State or Foreign Country) aryland
	/land		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo				1	10d. Inside City Limits
	the Mar 28a-f st	Director	MD Allegany 10e. Street and Number	7	Westernp	ort 10f, Zip Code		10	og. Citizen of What 0	MXYes 2 □ No
	23a or		301 Poplar St	•		2156		τ	United St	*
5-0036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show 'egical Examirer must be rolified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □Yes 2XX	spanic Origin? (Spen, Mexican, Puerto in Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. white
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Ĕ	ges 1 and 2 should be nt of Health and Mental If Item 27 Is marked or or other traumatic ev	_	19a. Informant's Name/Relationship (T) Barbara Winebrenne			ng Address (Street a Spruce St		,	,	, Zip Code) 21562
saitimore,	permit. Pages 1 am Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 123 Burial 2 ☐ Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		natory or other place cemetery	9 02/2 2009	21/ [Oc. Location - City of Vesternpo:	or Town, State rt Maryland
ga	permit Depar Impor any in		21. Signature of Funeral Service Licens 7. Wayne	Bal		2. Name and Address 11 Church	BC		ral Home , Maryland	d 21562
, F	Physician /Medical	0 3	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. CON	e death. Do not en	ter the mode of dying		or respiratory arre		Approximate Interval Between Onset and Death
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×	w requires that the death certific s been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	elivery Day Year
Л	ires that signed b		Part II. Other significant conditions co	entributing to death but n		nderlying cause give	n in Part I.			to the cause of death?
"	The law requate has been sage 2 should	Completed by						24a. Was an autopsy perform	24b. Were a prior to death?	autopsy findings available completion of cause of
VItal	iclan: certifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death	(Check only one)	
0	g Phys er this eral dir): T o	27. Manper of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time o	f 28c. Injury Works	4 A Hursing Hor	ne 5 Resider 28d. Describe hov	nce 6 Other (Sp	pecify)
IVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day, Ye	- At home, farm, str	M 1 □ Y	'es 2□No	28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
ָ ב	Hospital of hours a Funeral Ditely filled i	edical Ce	(Check only 2 Medical Exam	vsician: To the best of miner: On the basis of ex	camination and/or in	h occurred at the tim	ne, date and place, sinion, death occurr	and due to the ca	use(s) and manner te and place, and di	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	one) 29b. Signature and title of certifier	and manner stated	1.	29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
		4	1	//		De	4264	0	2/15/5	2009
1		6	30. Name and address of person who c Dr. Jesus Tan, 4				532			/
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 8 200	32. Registrar's	Signature	grife				

		1 - State of Maryland	-	ertment of F ctificate of			iene _{eg. No} 2009	07477
Physic /Med		1. Decedent's Name (First, Middle, Last) Mae Alice Reese Mosley				2. Date of Deat Month February	Day Year 23, 2009	3. Time of Death 1230 A M
Exami		4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center	r	4b. City, Town, o	r Location of Death		4c. County of Dea	
Funera Director		5. Social Security Number 228-34-5479 6. Sex 1 ▼ M 2 □ F 78	ns <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year 1930 9. Bin	rthplace (State or Foreign Country) irginia
ryland show	_		Town or Loc	cation				10d. Inside City Limits
the Ma 28a-f s	Director	Maryland Prince Georges 10e. Street and Number	Fairm	ount Hei	ghts	1	0g. Citizen of What C	1XYes 2 No
3a or	ig is	1025 – 58th Avenue		207	43		United Sta	,
C Z1Z13-UU36 filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ther than "natural" or items 23a or 28a-f show ent, the Madical Eventiner must be rotified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Wildowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	l II	Vas Decedent of F f Yes, specify Cuba	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Am Black, Whit Specify: B]	te, etc.
n 72 h	lete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	lent's Usual Occup kind of work done	oation during most of work d)	king	16b. Kind of Business	/Industry
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ryia nould to d Men marke natic	ြင	Thomas Reese	40h Mallin	a Address (Street	Matti			Zia Oada)
Manud 2 sl		19a. Informant's Name/Relationship (Type. Print) Corey Dean Jiles (Son)		-			; City or Town, State, leights - Mai	ry1and 20743
DEBILITION Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be redifficated any once.		1 23 Buriai 2 Li Cremation 3 Li Removal from State	ace of Dispos metery, crem enlawn	sition (Name of natory or other place Memoria . Name and Addre	Feb. 1 Gardens ass of Facility R.	28,2009 N. Horto	20c. Location - City or Chesapeake on Company	Town, State
hicate be executed / Medical Examiner and bhysician and street be urial-transit		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events tresulting in death) Last Luc to (or se a consequence of the cons	Encenter of the series of the					Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnand Other (specify)	гу		23d. Date of de Month	elivery Day Year
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VISION OF Attending Phy or death. ector: After this by the funeral d	ation: T		28b. Time of Injury	28c. Injur Wor	ry at	28d. Describe ho		zony)
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he Hospil in 24 hour he Funer: pletely fill-	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the ti	me, date and place opinion, death occu	, and due to the carried at the time, da	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
To t with To t	Σ	29b. Signature and title of certifier Degarder		29c. Licens	28/5		9d. Date signed (Mon. 2/23/4	
R		30. Name and address of person who completed cause of death (Item			o1 -	-		
	ate	Daniel Alexander, M.D.; 3001 Ho 31. Date filed (Month, Day, Year) 32. Registrar's Signatu		I Drive;	Cheverly	, Maryla	nd 20785	
Regis		31. Date filed (Month, Day, Year) Server 32. Registrar's Signature of the Server of	Ken					

Physicia /Medic Examin	al
Funeral	1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Evanityar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and impropered from the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

•	1 - State Registra AME	19aper	TH, 2-25-(09,EMW,Mc	b Ce	ertificat	e of L	Death			Reg. No).).	00	0 1	7 7 0
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 22 9 ☐ Unknown	months? ☑No	1 Live	tcome of pregna birth 2 Petal nant at time of do nown	death 3	B ☐ Ectopic p 5 ☐ Other (sp		1				23d. Dat Mo	e of deliventh		ear
Y P	Part II. Other signif	ficant conditions of	contributing to d	eath but not resu	iting in the	underlying c	ause give	n in Part	l.	23e. Did t	obacco	use conti	ribute to t	he cause of de	ath?
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Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Helen Mae Pergal Month Year 3:30a M February 20, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 411 Neale Avenue Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Hours 1 □ M 2 🛣 F Days Min 93 286-07-2421 Director August 3, 1915 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, it at Medical Examination at the notified at Director MD Montgomery 1 ☐ Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Neale Avenue 20901 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2xxNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2xxNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. Š Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Masterson ပ Margaret McCaffery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10904 Oakwood Street, Silver Spring, MD 20901 John Pergal 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or Feb. 24, 2009 Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Divi fo (or as a consequence of) physician and s the burial-transit Kyphoscoliosis Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Cther (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si 1 ☐ Yes 21X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) 1 Yes 2 **X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

law requires that the death certificate be executed Box 68760. Ö ۵. Records, Physician; The Division of Vital

death

72 hours after

Pages

Baltimore, Maryland 21215-0036

Certification: To Hospital or Attending death. nours after death.
neral Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral L 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely f (Check only one) the 29b. Signature and title of certifier

29c. License number D18813

29d. Date signed (Month, Day, Year) February 20, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10301 Georgia Avenue, Silver Spring, MD 20902 Ira Tauber, MD

State Registrar 31. Date filed (Month, Day, Year) FEB 23



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 07480 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harold Uriah Peddicord February 2009 16, 7:00 PM/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min. 1**⊠** M 2□ F Months 577-22-5301 Director 9, Feb. 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, I've Wedical Examination of different Director Maryland Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14217 Day Road Funeral 20850 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. rmed Forces?

XYes 2 \sumbox No World 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: War II 1 □Yes 2 🛣 No Specify: \$ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Supervisor Public Schools 12 marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel H. Peddicord Esther B. Heeter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Dunlap (Sister) 190 Freedom Way, Warsaw, VA 22572 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 20, 4 ☐ Donation 5 ☐ Other (Specify) Gaitherbsurg, Maryland 2009 Cemeterv 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, then t failure. List only one cause on each line. Approximate Interval Between Onset and Death use (First Physician resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any leading to in the distance cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. à signed if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1∐Yes 2∭2No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate perform 1 □ Yes 2 No 1 ☐ Yes 2 ☑ No this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft. completely filled in by the fun 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day,

FEB

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Year)

23

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 February Lee Sukki Paik 20, 00:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) MAR 1, 193 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 72 Director 214-64-2171 1936 Korea Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a the offer Examiner must be notified at once. Director 1 ☐ Yes 2√2 No Maryland | Howard Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8290 Mary Lee Lane 20723 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Manager Property Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paik Namhyok ပ Poksang Park 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Paik / Son 2715 Summers Ridge Dr., Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 02/26/2009 Fairfax Mem. Park Fairfax, Virginia 21. Signature of Funeral Service L 22. Name and Address of Facility Fairfax Memorial Funeral Home M00956 9902 Braddock Road, Fairfax, VA 22032 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronary a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h perform 1 ∐ Yes 2 **☑** No 2 □No 1 ☐ Yes funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Minpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 ☐ Homicide 24 hours a 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 1 within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7901 Maple Ave., Takoma Park, UD BRILL WIL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 23 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:10 DM Mayme Frances Pacini February 17 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours Min Director 104 212-74-1977 January 13, 1905 Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ō 23a 3124 Gracefield Road, Apt. #303 20904 Montgomery Funeral items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 🖾 No be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1□Yes 2档No If Yes, Give Year or Dates: Specify þ Specify: 3 ☑ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "ne any injury or other traumatic event in any injury or other event injury or other (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telecommunication 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Harry Lynn Brandon Fannie Synder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. Rawlings - Daughter 3124 Gracefield Road, #303, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 02/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. | 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Imme #11e Cause (Final **Physician** Hyrertensive Cardiovascular Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dementia Years Sequentially list conditions, if any landing limit find cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of certificate be executed for use as the burial-transi Osteoarthritis Years and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal dea The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for Ö 1 ☐ Yes 2 ☒ No 9 Unknown 9 Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🛭 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1∐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 X Natural ours after death.
neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D., 14300 Gallent Fox Lane, Suite 222, Bowie, Maryland 20715 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician February21, 200⁶9° 11:15 AM **FRANCES** Т. PYNN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Prince George's Renaissance Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Days 1918 N.Y. N.Y. 91 088-03-9426 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhermat be notified at once. 1 □Yes 2 No Prince George's Silver Spring Director Maryland 10f. Zip Code 20904 10g. Citizen of What Country? 10e. Street and Number 3160 Gracefield Rd. OG 3143 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Never Married 2 Married
Widowed 4 Divorced 1 Tes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No Specify Specify: Completed by White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Hartman Thiele George ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Margate Rd. Lutherville, Md. 21093 Louise Lewis / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Feb. 26, 2009 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses 4400 Powder Mill Rd. Beltsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physlcian: The law requires that the death certificate be executed Severe Dementia Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Year Month Day 5 ☐ Other (specify) P.0. 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 □Yes 2 □No filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 4 ☐ Homicide 29a. Certifier 1 Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical n/v 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Nurse Practitionemer stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of persor

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.0.0.0

			1 - For State Registrar	Oldio of Mi	ai yiailu		tificate of l			leg. No.	09	0/484
	Physici	an.	1. Decedent's Name (First, Middle,	Last)				· ·	2. Date of Dea	th	Voor	3. Time of Death
_	/Medic			Philip Portn	оу				Februs	0 7	<u> </u>	1640 M
	Examin	er	4a. Facility Name (If not institution, 2600 Quee		l Ra	ad		Location of Death		Prince		ema (c
Ī	Funeral			6. Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birth	place (State or Foreign
П	Director		578-40-1283 Usual Residence of Decedent	1⊠M 2□F	84	Yrs.	World Days	riours Will.	December			ntry) Germany
	land low		10a. State 10b. County		10c. City,	Town or Loc	ation				—- T:	10d. Inside City Limits
	a-fsh	ctor	Maryland Prince	e George's			Hva	ttsville				1 □Yes 2 ☑ No
	vith th	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Cour	ntry?
	eath v	Funeral	2600 Queens Chape	12. Was Decedent		12 1/		0783	acifu Va a or Na		U.S.A	
و	after d or iten ningr		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 √ Yes 2 □ N			Vas Decedent of Hi Yes, specify Cuba		Rican, etc.)		k, White,	can Indian, etc.
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jical Examinet must be redified at	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII		□Yes 2k No	Specify:		Specify		White
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717	d within giene. rr than "I	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)		Radio Repai			TV/Rad	io Re	pair
and	be filed within 72 hours after death with the Marylan and Hygione. In Hygione. In Hygione. In It has "natural", or items 23a or 28a-f show event, the fred the filed at event, the fred the filed at the fred t	Be (17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle, M			
5	should be tnd Menta s marked umatic ev	10	Ukn		-			Ukn				
Ž	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship Bernard Abeshouse -	, , ,	Ī		g Address <i>(Street a</i> Sarah Drive					o Code)
w	es 1 ar of Hea item rothe		20a. Method of Disposition	-	20b. Plac	e of Dispos	ition (Name of atory or other place	1		20c. Location -		own, State
Ĕ	Pages ment of ant: If its lury or o		1⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemetery		5/2009	Washingto	n, D.	С.
ng n	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	ensee		Hi	Name and Addres nes-Rinald:	i Funeral I	Home, Inc.			11:
			23a. Rart 1. Enter the disease, or co	omplications that caused	the death	Do not ente	.800 New Har	mpshire Ave	enue, Silve	er Spring	, Mar	yland 20904
	hysician		Immediate Cause (Final	ity one cause on each lin	e.		200					Approximate Interval Between Onset and Death
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	Examiner	Ļ	Sequentially list conditions,	b		-11-5-20-1						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the desired exercises)	Due to (or as a	eonsequen	es of):						
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5	iral or irs afte ral Dir lled in	Ser	7/.	building, etc.					City or Town,	, State)		0
	To the rospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) 1 ☐ Certifying 2 ☐ Medical Ex	Physician: To the best of aminer: On the basis of and manner stat	examination	dge, death and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and mar ate and place, ar	ner as s	tated. the cause(s)
1	withis To th comp		29b. Signature and title of certifier	1 -1			29c. License	number	29	d. Date signed	(Month, I	Day, Year)
1	611		Salador	Sprate	DDo		Hous	57927	Î	ebrua	y à	2005
			30. Name and address of person wh	o completed cause of de	ath (Item 23	a) (Type, P	House don't	a cho-	2. 8	11.	1	,
	Stat	e	31. Date filed (Month, Day, Year)	32/Registra	r's Signature		- Corin	9	ry,	larg	land	
	Registra	ır	FEB 24 2	2009 Deneus	J A.	par	Kel					

Certificate of Death

1 - For State Registrar

Physicia	n	1. Decedent's Name (First, Middle, Last) MARY EDITH SAVOY F	PROCTOR				2. Date of Dea Month FEBRUA	RY 19, 2009	3. Time of Death 1545 M
/Medica Examine		4a. Facility Name (If not institution, give s FORT WASHINGTON HO	street and number)			or Location of De	eath	4c. County of Dea	th
Funeral Director			1 to 0 0 0 0	vrs. last birthday) 2 Yrs.	If Under 1 Year Months Days		lrs. 8. Date of Birth lin. (Month, Day NOVEMBER	2, 1916 MAR	thplace (State or Foreign puntry) YLAND
Maryland -f show fied at	Ì	Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARLES		City, Town or Lo	cation			a.#i	10d. Inside City Limits 1 □ Yes 2 □ No
with the	Direc	10e. Street and Number 2385 DAVIS ROAD			10f. Zip Code 2060	3	1	Og. Citizen of What Co	•
rs after death I", or items 2 xaminer mus	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Midowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of f Yes, specify Cu		(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6TH GRADE	cation e completed) College (1-4or 5+)	(Give life, L	lent's Usual Occu kind of work done OO NOT use retin	upation e during most of v ed)	working	16b. Kind of Business. FOOD SERV	·
uld be filed Aental Hygi rked other tic event, t	lo Be	17. Father's Name (First, Middle, Last) WILLIAM WALTER SAV	OY.				Name (First, Middle, ERNETTE P		
and 2 shoresth and 8 127 is ma		19a. Informant's Name/Relationship (Type CATHERINE E. HARLE					DORF, MAR	r, City or Town, State, . YLAND 2060	
Pages 1 ament of He ant: If Item ury or other		20a. Method of Disposition 1 X Bunal 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	amousi from State		natory or other pl			20c. Location - City or POMFRET, MA	
permit. Departimonts any inj		21. Sonature of Funeral Service License	CHNSON MOOS83	ے ا	HORNTON 3439 LIV	FUNERAL INGSTON	HOME, P.A ROAD, IND	IAN HEAD, N	IARYLAND 20640
Physician //Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the decause on each line. ISCHEMIC C Due to (or as a cons	ARDIOMYC		ring, such as card	diac or respiratory arr	est,	Approximate Interval Between Onset and Death YEARS
Examiner	_	Sequentially list conditions,	AZOTEMIA Due to (or as a cons						YEARS
eath certificate be executed attending physician and for use as the burtal-transit	נ <u>ַ</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ATRIAL FIB	RILLATIO	ON .				YEARS
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igne be c	2	Part II. Other significant conditions cor	ntributing to death but not	resulting in the ur	nderlying cause g	iven in Part I.	23e. Did t <i>o</i>	bacco use contribute to	o the cause of death?
ystclan: The law requires that the is certificate has been signed by th director, page 2 should be detached.	Completed						24a. Was a autops perfor	24b. Were at prior to death?	utopsy findings available completion of cause of
certificate		25. Was case referred to medical examiner?					Death (Check only on		
Physic r this corral dire	<u> </u>	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury	2 ER/Outpatien 28b. Time of	1 3 DOA			ence 6 Other (Spe	cify)
Attending Physician: r death. ector: After this certificity the funeral director.	Certification:	1 Accident 3 Suicide 1 Accident 5 Pending investigation 6 Could not be	(Month, Day Year		M 1[Yes 2 No			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	ecify)			City or Town		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the vestigation, in my	time, date and pl opinion, death o	ace, and due to the c ccurred at the time, c	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
To t To tl	2	29b. Signature and title of certifier	Chanil	vur)		se number		9d. Date signed (Moni FEBRUARY 20	
BB3	-	30. Name and address of person who co				AL, 1171			-

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 4 2009

			1- State of Maryland / Department / Department / Department / Department / Department / Departme	artment of Health and M rtificate of Death		ne No.2009 07486
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici: /Medic		Kenneth Postlewaite		February	y 14 2009 <i>2030</i> M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
ď			4828 Woods Wharf Rd.	Shady Side	0.0.4 (5).11	Anne Arundel
п	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb 13	9. Birthplace (State or Foreign Country) California
			Usual Residence of Decedent		100 15	1954 Callionna
	rylandihow	_	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	8a-f s	Directo	Maryland Anne Arundel Shady			1 ☐ Yes 2 🌠 No
	vith th		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 236	eral	4828 Woods Wharf Rd.	20764	ocifu Voc or No	USA 14. Race - American Indian.
· _	fter de	Funeral	1 Navar Marriad 0 Naviad 1 TVVac 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modical Exertainer mast be neithed at	l by	3 Widowed 4 Topiorced The State 1977-79	1 □Yes 2X No <i>Specify:</i>		Specify: Black
2-0	72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation		o. Kind of Business/Industry
12	vithin	mp	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	Hygie Hygie ther t		12th 0	Laborer 18. Mother's Name	(First, Middle, Maid	Self Employed den Surname)
ă	should be I and Mental s marked o umatic eve	To Be	Lucius Postlewaite	Sarah		
ary	should be ind Mental imarked c	-		ng Address (Street and Number or Rura		ity or Town, State, Zip Code)
	es 1 and 2 should b of Health and Meni f Item 27 is marked r other traumatic e	1	Michael E. Postlewaite(Brother)	1345 Walnut Av	e Anna	polis, Md. 21403
ore	of He fler		20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State	osition (Name of D matory or other place)	ate 200	c. Location - City or Town, State
Ĕ	Pages ment of ant: If Its ury or o		4 Donation 5 Other (Specify) Marylan	d Veteran 2-23		rownsville, Md.
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o			Mame a RAMES of Acids On S		A 1 No Code
	TO = 60			321 West St. Ann		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause in each line. Immediate Cause (Final		-	Interval Between
ا برا	Physician /Medical		disease or condition a.	votic steart	Dise	ASR
	Examiner		Due to (or as a consequence of):	5100		
		Jer	Securification difference b. Due to (or as a consequence of): cause. Enter Underlying	516.	-	
	ocuted nd transit	Examine	Cause (Disease or injury that initiated events c.			
Ď,	be executed ician and ourial-transit	Ě	resulting in death) Last Due to (or as a consequence of):			
9/8	ate physi	dical	d			
S S	ding	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
X R R	death	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
5	the character the	hys	9 Unknown		-	
	requires that been signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
D D	equire				1 ☐ Yes	2 No 3 Probably 4 Unknown
Hecords,	law r nas be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I a	t: The	Co	-7.4		performed 1 □ Yes 2	
Ë	sician certif rector	Be	25. Was case referred to medical examiner? 10. Hospital: Hospital:	26. Place of Death		
ō	Phys	2	27. Manner of Death 28a. Date of Injury 28b. Time o	11. 3 DOX 4 I Nursing Hor	ne 5 Residence 8d. Describe how in	e 6 ☐ Other (Specify)
0	nding th. : Afte e fune	tioi	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISION	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
5	rs after al Dir	Certification:	Dullung, etc. (Opecary)		City of Town, 3.	iate)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	edical	29a. Certifier (Check only 2 Medical Examiner: On the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a evestigation, in my opinion, death occurre	and due to the caus ed at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	ithin 2 the o the omple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	F \$ F 5	1	111.41 Deput	D06050	4	2/17/9
1	Story.	Y	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	`	, , ,
Υ.	1000		Welliam P. Jones, uno	695 Americ	A 2	1035
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 0 2009	ha. V. I		**
	Registr	ar	LU & U COUS Server B.	vaire		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo State Registrar #22, perF. Home, 2/25/09, BA Certificate of DeathwCHD Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year ELIZABETH ANN PARKS EbRUSAY 03:52 2009 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEdical SALISBURY
If Under 1 Year | If Under 24 Hrs. Wicomico 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□ M 2 ⋤ F 220-32-2416 73 Director 08/15/1935 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State show 10d. Inside City Limits the Medical Exercitive must be nutflied at Director 1 ☐ Yes 2 ☑ No Worcester MD Girdletree 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3 5925 Taylor Landing Road 21829-0149 USA Funeral items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. laborer Hotel 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William Robert Esterline Irene Virginia Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Mary L. Dimmick/ sister 121 8th Street, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Girdletree Bapt. Qem 2/28/09 Girdletree,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOLLOWAY 103 Linden Ave. Holloway Holloway Funeral Home, P.A. Pocomoke City, MD Much 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumo /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Lectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only within 2 To the

BA 10

State

FEB 25 Registrar

DIMONA

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ENG DO

SALISBURY Md 2180 32. Registrar's Signature auce

100 E CARROLL ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			State of Maryla				-	_	ible.	
			For State Of Walty 16 State Registrar		rtificate of			leg. No. 2	09	07488
			Decedent's Name (First, Middle, Last)				2. Date of Dea		3	. Time of Death
Н	Physici		Delores Parks				Feb 16	Day	Year	9:13 a ^M
2	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County		7.13 a
7	LX		2822 Eliston Street		Bowie				e Georg	e's
	Funeral		10.00	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplace	(State or Foreign
	Director		579-74-4368 1 M 2 F 65	Yrs.			Feb 8 1			ngton, DC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d.	Inside City Limits
	Maryl f she	ρ	MD Prince George's Bo	owie						1 x Yes 2 □ No
	r 28a	irec	10e. Street and Number	JWIE	10f. Zip Code		1	0g. Citizen of V	What Country?	
	h with	Funeral Director	2822 Eliston Street		20716			USA		
	ems deat	iner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. 1	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		ce - American I	ndian,
36	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		1 □Yes 2½ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		y: Black	
00	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show ne Neolical Examiner must be neofited at	q p	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	16a Daga	dont's House Ossum	ation				
15	in 72	ojet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of work d)	king	16b. Kind of Bu	usiness/industi	ıy
212	with giene r thau	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	Nursi				Privat	te	
b	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I	Maiden Surnam	ne)	
Vlai	Menta Menta arked	To E	Clarence Bullock			Edna M	ae Fowle	r		
lar	2 sho		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street				State, Zip Coo	de)
<u>≥</u>	and lealth rm 27		Edna Dillard/daughter		Eliston S					
jor	iges 1 nt of H if ite or ot				osition (<i>Name of</i> matory or other plac			20c. Location -		
Baltimore, Maryland 21215-0036	er nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan be artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examples must be notified at an 28.				ans Cemet		2009 C	Chelten		•
Ba	e a si mpor in		21. Signature of Funeral Service Lieutee		2. Name and Addre					
		\vdash	23a. Part1. Enter the disease, or complications that caused the de	•	474 Lando					20785 proximate
	Physician		shock, or heart failure. List only one cause on each line.		,	9,	, , , , , , , , , , , , , , , , , , , ,		Inte	erval Between set and Death
	/Medical		disease or condition resulting in death) Cerebral Due to (or as a cons							
	Examiner		Cerebral	Metasta	ısis					
	p #	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	equence of):						
	ecute and trans	Ma	Cause (Disease or injury that initiated events resulting in death) Last c. Lung Cand							
760,	be ey	calE	d Spinal Me		· s					
687	ficate p phys s the		d. Spinar ite	.cas cas i						
Box	eath certificate be executed aftending physician and for use as the bunal-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		75			23d. Dai	te of delivery	
B	deat of for	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown		Dectopic pregnanc Other (specify)	у		Мо	onth Day	/ Year
P. 0.	that the dened by the a	Phys	9 Li Unknown				T == =			
Š,	res th	þ	Part II. Other significant conditions contributing to death but not represent the Diabetes CVA	asulting in the ur	nderlying cause givi	en in Part I.		bacco use cont		
000	ding Physician: The law requires h. After this certificate has been sign funeral director, page 2 should be	eted					-		3 Probably	4 Unknown
Bec	has ge 2 s	mpl	Hypertension				24a. Was a autops perforr	y	Were autopsy prior to comple death?	findings available etion of cause of
ā	in: The		25. Was case referred to medical				1 □ Yes 2	2 ⊠ No	1 ☐ Yes 2 🗓	No
Ē	/sicia s cert directe	o Be	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2	☐ EB/Outpatier	ot 3 🗆 DOA Othe	26. Place of Deat	m (<i>Cneck only on</i>		or (Caralta)	
o l	g Phy terthi	Ĕ	27. Manner of Death 28a. Date of Injury	28b. Time of			28d. Describe ho			
Ö	tendin death. tor: Af the fur	atio	2 Accident investigation	li l		Yes 2 □ No				
Division of Vital Records,	or Attendatter deatt after deatt Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Numb	er or Rural Ro	ute Number,
Ω	urs af									
	Hospita 24 hours Funeral stely filled	Medical	29a. Certifier (Check only one) nowledge, death nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occur	, and due to the c red at the time, d	ause(s) and ma ate and place,	anner as stated and due to the	d. cause(s)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Mec	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed	d (Month, Dav.	Year)
	F > F 0		1 Ame Mil		D4039			ebruary		· ·
۰	2		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print)				-	
12			Saraswathy Ramachadran M.D.			Lane Larg	go, Mary	land 20	774	
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Sig							
	Registr	ar	FEB 2 5 2009 Sener > 1. 1	#C						

DHMH 17 Rev 1/2001

State Registrar

Maryland 21215-0036

Box 68760,

P.O.

Records,

30. Name and address of person who complet to cause of death (Item 23a) (Type, Print)

Registrar's Signa

Brian Carpenter, M.D.,

31. Date filed (Month, Day, FEB 2

D0064502

9901 Medical Center Drive, Rockville, MD 20850

February 19, 2009

			1 _ State	artment of Health and Nertificate of Death	Mental Hygiene Reg. No. 2009 07490
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Death 3. Time of Death
	Physici /Medic		Sophia Amelia Ryder		February 21, Year 6:00 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
page .			8821 Sundale Drive	Silver Spring) If Under 1 Year If Under 24 Hrs.	Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. last birthday of the second of the sec	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 13, 1927 9. Birthplace (State or Foreign Country) New York
	Maryland f show	for	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Montgomery Sil	ocation ver Spring	10d. Inside City Limits 1 ∑ Yes 2 ☐ No
	r 28a-	irect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with	a D	8821 Sundale Drive	20910	USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examirar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 1 No Specify:	pecify Yes or No- D Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	hin 72 hou e. an "natura Medical E	Completed	15. Decedent's Education 16a, Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	16b. Kind of Business/Industry
2	ygien ygien ier th	Con	2 C	pordinator	County Schools
land	uld be filk Mental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) Sam Sickowich		e (First, Middle, Maiden Surname) Smaschuck
, Maryland	and 2 shousaith and N 27 is mai				ral Route Number, City or Town, State, Zip Code) lexandria, VA 22309
altimore,	Pages 1 annung Pages 1 annung Perung		1 L Burial 2 K Uremation 3 L Hemoval from State 1	matoni or other place)	Date 20c. Location - City or Town, State Ceb. 25 Alexandria, Virginia
Balt	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins 500 University Rly	Funeral Home Inc.
	iticate pe executed // Medical Examiner sthe purial-transit sthe purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arrhythmia Due to (or as a consequence of): Cardiomyopathy Due to (or as a consequence of): C. Due to (or as a consequence of):		Onset and Death
. Box 6	death certi e attending d for use a	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the Atrial Fibrillation	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown
Hec	The law re- ate has bee page 2 sho	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes 2 No
VITAI	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		th (Check only one)
5	Phys rthis ral dir	은	1 Yes 2 No Prospiration 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of Death		ome 5 ☑ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
0	Attending r death. ector: After by the fune	igi	1XNatural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident Investigation	Work? M 1 □ Yes 2 □ No	200. Describe now injury occurred
UIVISION	al or Atter after dea I Director d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendin within 24 hours after death. ✓ To the Funeral Director: Aft completely filled in by the fur	Medical C	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, deal of the best of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
)	within comp.	Me	29b. Signature and the of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Nasreen Kango, MD 7610 Carroll Ave	Print) enue, Takoma Park,	MD 20912
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 4 2009		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Februar ARGARET 18, 2009 MCDONALD ROBISON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 1 M 2 KF Year) Months Days Hours Min. 236-40-8451 80 Oct.20, 1928 West Virginia Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Williamsport Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 16814 Tammany Manor Rd. 21795 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Deceden. _ Armed Forces? 1 □Yes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Clerk Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Howard Toup McDonald Mildred Virginia Small 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> John J. Robison - Son</u> <u>118 Deep Dale Drive Timonium, Maryland</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Feb.23,2009 Hagerstown, Maryland 21. Sign were of Funeral Super OSBUTTE AFORTEFEITH HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 ☐ Yes 2 ☐ No

Examiner Box 68760 P.O.

Funeral

Director

show

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

72 hours after death with

filed within 7 I Hygiene.

s 1 and 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th

permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any injury or other trai

Physician

/Medical

traumatic

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical the ģ signed det Records, ģ Completed s certificate has bi lirector, page 2 sl of Vital Be Medical Certification; To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral Division 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 29b. Signature and title of

29c. License number 200614/1

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110 MEDICAL CAMPUS RD STE 150 HAMERSTOWN MD 21742 KRISHNAMOCRTHY

State Registrar

To the within 2

Pł	ıy:	sic	cia	ın
1	M	ed	ic	a
	хa	mi	in	eı

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Madical Examinar must be notified at anothes.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

BAIDH Sta

State Registrar		Ce	ertificate of	Death		Reg. No. UU	9 0149
1. Decedent's Name (First, Middle, Las	(t)				2. Date of Dea	ath	3. Time of Death
Howard R. Ruther	ford				Month 2	23 200!	9 1:30 P
4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of D	
Atlantic General	Hospital		Berlin			Worces	tar
5. Social Security Number 6. Se		yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 0	Birthplace (State or Fore
228-26-8972	XIM 2□ F 8:	Yrs.	Months Days	Hours Min.	3/28/1	927	VA
Usual Residence of Decedent					10/00/0		471
10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Lim
MD Worcest	er	Ocean C	itv				1 X Yes 2 □ 1
10e. Street and Number		occuii o	10f. Zip Code			10g. Citizen of What	Country?
10135 Queens Circ	ام		2184	12		USA	ŕ
	12. Was Decedent Ever	in II S 13	. Was Decedent of H		pecify Ves or No-		merican Indian.
11. Marital Status 1 □ Never Married 2XXXMarried	Armed Forces? 1 X Yes 2 □ No	10.0.	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, W	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 □XNo	Specify:		Specify:	white
		160 Door	adontia Haval Oscum	ation		10h Kind of Duning	
15. Decedent's Ed (Specify only highest grad	de completed)	i (Give	edent's Usual Occup e <i>kind of work done (</i> DO NOT use retired	durina most of work	king	16b. Kind of Busine	ss/industry
Elementary/Secondary (0-12)	College (1-4or 5+)	_	_	,		Canatuu	. 4 / C
11		Joupe	<u>erintender</u>		- /Einch 2011		tion/Steel
17. Father's Name (First, Middle, Last)	C					Maiden Surname)	
William J. Ruther				Minnie	Pearson		
19a. Informant's Name/Relationship (7		1	= .			er, City or Town, State	
Nancy Rutherford /	<u>wife</u>	1013	35 Queens	Circle,	Ocan Cit	ty, MD 218	42
20a. Method of Disposition	2	20b. Place of Disp	osition (Name of ematory or other place	(e)	Date	20c. Location - City	or Town, State
1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	astern S	Shore Vet	Cem 2/26	5/2009	Hurlock,	MD
21. Signature of Funeral Service Licens	′L		22. Name and Addre				
him Ma	2 dead			, B	urbage 1	uneral Ho	me
Jil Cila	01400		108 Willia				American
23a. Par 1. Enter the disease, or comp shick, or heart failure. List only of	ne cause on each line.	death. Do not er	iter the mode of dyir	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Cerebrov	ascular	accident	in brain	stem		Oriset and Death
resulting in death)	Due to (or as a co						
Comments II all the comments	Hyperten	sion		•			
Sequentially list conditions, in any, leading to immediate	Due to (or as a co	nsequence of).					
cause. Enter Underlying Cause (Disease or injury that initiated events	Coronary	Artery					
resulting in death) Last	Due to (or as a co						
	_ Alcohol	withdraw	I				
	u						
IF FEMALE:	23c. If yes, outcome of pr	regnancy				201 0 1 1	1.0
in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnanc	y		23d. Date of Month	Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	e or death 51	Other (specify) _				
Part II. Other significant conditions co		A seculation in Alexan		en in Best I	no- Dida-	h	
chronic alcoholi		it resulting in the t	indenying cause give	en in Fari I.			to the cause of death?
					1 □ Y	es 2∐No 3∐	Probably 4 \ Unknow
chronic kidney d	isease				24a. Was a		autopsy findings availat
					autop: perfor	med? death	
25. Was case referred to medical				00 00 10			es 2□No
examiner?	Hospital:	0□ E0/0 :	ort a 🗆 DOA Othe	26. Place of Deat			
1 Yes 2 No 27, Manner of Death	1 XJ Inpatient 28a. Date of Injury	2 ER/Outpatie	III 3 LI DOA	4 LI Nursing Ho		ence 6 Other (S	pecify)
1 Natural 5 Pending	(Month, Day, Yea	ar) Injury	Work		Zou. Describe N	ow injury occurred	
2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my	y knowledge, dea	th occurred at the tir	ne, date and place	and due to the	cause(s) and manner	as stated.
(Check only 2 Medical Exam one)	iner: On the basis of exa and manner stated.	irriination and/or ir	nvestigation, in my o	pinion, death occur	rred at the time, o	tate and place, and c	lue to the cause(s)
29b. Signature and title of certifier	. 171-	7	29c. License	number	2	29d. Date signed (Mo	onth, Day, Year)
72 STA	1111 Ma	AHR.	nding	7012	12	17/12	12.00
20 100	- NAMAN 1 4	1111111		V167	16	00/27	1007
30. Name and address of person who		TITEM 23a) (Type,	722 il	thury	7)	Bal.	MADORE
31. Date filed (Month, Day, Year)	tavnuas, 32. Registrar's S	Pianotura	1771/76	cinuay	Drive	Derlin,	1711/201
FER 9 7 9	000 Legistrar's s	Jigirature A	had 1	/		,	
FFD Z / /	LICEMEL AND	577 /	22 17 A 18 10 11				

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Joel Lee Richardson	1- For State Registrar			Health and Me	ntal Hygiene	eg. No. 200	9 0749
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,La Joe I	st) Lee Richar	dson		2. Date of Deat Month February 2		3. Time of Death 0223 hrs
	4a. Facility Name (if not institution, g 8 Greenspring Road	ve street and number)	4	b. City, Town, or Locatio Charlestown		4c. County of Deat	h
Funeral Director	010 10 5044	Sex 7. Age (In X M 2 F 3	yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	uso Min		rthplace (State or
any	Usual Residence of Decedent 10a. State 10b. County		. City, Town or Location	on .		,	10d. Inside City Limits
rith the Maryland s. 23a or 28a-f show s notified at once. all Director	Maryland Ceci			Charlesto 10f. Zip Code		0g. Citizen of What Cou	1 Yes 2 X No
with the M s 23a or 2 e notified ral Dire	8 Greenspring I	Road	rin U.S. I 13 Was	21914	rigin? (Specify Yes or No	U.S.A.	rican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trammatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 X Marrie 3 Widowed 4 Divorce	d Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No 1	s, specify Cuban, Mexicovers $2 \overline{X}$ No specific	an, Puerto Rican, etc.)	White, etc. Specify:	White
5-0036 led within 72 hours Hygiene to ther than "natur the Medical Exam Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12) Twelve Years	College (1-4 or 5+)	during mo	s Usual Occupation (Giv st of working life, DO NO rack Worker		Amtrak Ra Washingto	ilroad
21215-0) ould be filed with Mental Hygic marked other ic event, the M		in Richardso			er's Name (First, Middle, N Susan Mo	ontville	
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship Dana S. Richardso	on (wife)	8 Gre	enspring Ro	umber or Rural Route Num ad, Charlest	own, Maryl	and 21914
Baltimore, permit. Pages I ar Department of Hee Important: If ite njiury or other tr	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specification 3	Removal from State	crematory or oth Asbury C	emetery		•	it,Maryland
<u> </u>	21. Signature of Funeral Service Lie 23a. Part I. Enter the disease, or con	adosono	Lee	ame and Address of Faci A. Patters Perryvill	on & Son Fur	neral Home, 21903-07	P.A. 66
Physician /Medical xaminer	failure. List only one cause on a Immediate Cause (Final disease	each line. . Contact Gunshot W	ound of Head	e mode of dyińg, such as	s cárdiac or reśpiratory arm	est, shock, or heart	Approximate Interval Between Onset and Death
10	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent). Due to (or as a consequent)					
ted Insit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent			_		
e execucian and rial - tra	UNPENDED	AMENDED					
Records, P.O. Box 68760 The law requires that the death certificate b cate has been signed by the attending physinage 2 should be detached for use as the bucknown completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Feta	al death 3 Ecto	pic pregnancy	23d. Date of deliver Month	y Day Year
, P.O. Boxers that the deatl res that the deatl signed by the att be detached for deatl by Physical by	Part II. Other significant conditions	contributing to death but	not resulting in the ur	derlying cause given in		obacco use contribute to	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P					1 🗸 Yes	psy prior to rmed? death?	utopsy findings available completion of cause of
f Vital Physician or this cert ral directo	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient	Othor	Nursing Home 5	Residence 6 🗸 Othe	er: Scene
ion of ttending P leath. ttor: After tthe funera	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day, Year) FOUND: tion Feb 23, 2009	28b. Time of In FOUND: 0208 hrs	iury 28c. Injury at Wo	 Subject show 	how injury occurred t self	
Division o ospital or Attending hours after death. uneral birector: Aftigited in by the function is Certification:	3 Sulcide 6 Could no determin	t be 28e. Place of Injury -		, factory, office building,	or Town, S		ural Route Number, City , MD
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Fineral Director: After this certificate I completely filled in by the funeral director, page	one) 2 Medical Examine	cian: To the best of my kno er:On the basis of examinat and manner stated.		on, in my opinion, death	occurred at the time, date	and place, and due to the	ne cause(s)
2	29b. Signature and title of certifier Panul Pyuthe	ulli mil		29c. License number	er ——————	29d. Date signed (Mo	
4	30. Name and address of person who Pamela E. Southall, MD	completed cause of death Assistant Medical	. ,	Penn Street, Balti	more, MD 21201		
State Registrar		32. Registrar's Si	gnature A. Jan	KN			

09-01723 John Preston Riggs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 07494

		1- For State Registrar	_	Ce	rtificate	of Deat	h			R	eg. No.		
Physicia		Decedent's Name (First, Middle,	Last)					14.1	2.	Date of Dea		Voor	3. Time of Death
edical Examir		JOHN PREST	ON RIGG	S						Month February	Day 28, 2009	Year)	1424 hrs
		4a. Facility Name (if not institution,	give street and nu	mber)			Town, or Lo			37.56	4c. Co	ounty of Dea	th
		7038 Detroiter Place					ns Road					arles	
Funeral		1	. Sex	7. Age (In yrs.	last birthday)	If Und Month	er 1 Year	If Under Hours	1.60		,	1 c	Birthplace (State or Foreign Country)
Director		217-80-1708	1 X M 2 ¥ r	44		Yrs.	ls Days	Tiodis	I VIII.	03-12-	-1964	Ca	mp Springs,M
	į	Usual Residence of Decedent											
y any		10a. State 10b. County		1	y, Town or Lo								10d. Inside City Limits
and shov	ᆡ	Maryland Prince	George's	3	Accol	keek							1- Yes 2 No
faryla 28a-f	ect	10e. Street and Number				10f. Zip	Code			1	0	of What Co	ountry?
ith the Maryland 23a or 28a-f show notified at once.	늅	15911 Manning H	Road West			2	20607				Ţ	USA	
with	Funeral Director	11. Marital Status	40 M/on Dog	adent Ever in I		Was Decede	ent of Hispa				- 14.	Race - Ame White, etc.	erican Indian, Black,
death r ite	un	1 Never Married 2 Mar	ried Armed Fo	orces?		If Yes, speci			rueito Ni	cari, etc.)		wille, etc.	
after al", o	by F	3 Widowed 4 TDivor	ced If Yes, Give Yea	ar	1	Yes 2	[™] No	specify:			Sp	ecify:	White
natur	ᅙ	15. Decedent's Education (Speci				dent's Usual g most of wo					16b. Kind	d of Business	s/Industry
6 72 h an "r cal E	Completed	Elementary/Secondary (0-12)	College (1	1-4 or 5+)						,	D .	. 7	. 1
within rene.	Ĕ	12th	<u> </u>		U	nion C							Industry
Hyg doub	ပ္ခု	17. Father's Name (First, Middle, L	,				18		,	rirst, Middle, Cool		name)	
11215-0036 the filed within 72 hours after death fedtal Hygiene. narked other than "natural", or iter event, the Medical Examiner must	Be	James L. Rig			I 10h Ma	ilina Address	S /Street		-			or Town Sta	ate, Zip Code)
Shou shou and N	은	Mary C. O'Donne		r		11 Man							
MOTE, MD 21215-0036 Pages I an £ 2 should be filed within 72 hours after death with the Maryland and of Heaths and Mental Hygene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	H	20a. Method of Disposition	JII/ MO CITC		. Place of Dis					Date			or Town, State
Ore		1 * Burial 2 Cremation	3 Removal fr	om State		r other place			02.0	7 00	Curia	-1	M1d
timent report		4 Donation 5 Other Spe			edar H	2. Name and				7-09	Suli	tand,	Maryland
Baltimore, MD 21215-0036 permit Pages 1 ar 1.2 should be filed within 72 ha Department of Health and Mental Hygene. Important: If item 27 is marked other than "in injury or other traumatic event, the Medical E.		21. Signature of Funeral Service L	MA	1374						DA Asse	S 11-	itland	20746 1, Maryland
	\dashv	23a. Part I. Enter the disease, or c											Approximate Interval
Physician		failure. List only one cause of	n each line.										Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	a Hyperte	ensive a consequence	athero	sclero	<u>otic</u>	card	iovas	scular	dise	ase	- Journ
			b.	consequence	01).								
40,00	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):			1					
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ficate be executed g physician and the burial - transit	edical	X UNPENDED	AMENDED	23a,27	,perME	, g889	9 3/2	6/09	TT	_			
760, ficate be g physici the buri	e	IF FEMALE:	23c If yes	per fl outcome of pre	h_g889	3-31-	-09 v	t		_	23d F	Date of delive	erv
876 tifficating phases the		23b. Was decedent pregnant in the	1 Live b	outcome of pre	2	Fetal death	3	Ectopic	pregnand	су		onth	Day Year
i, P.O. Box 68: ires that the death certification is generally the attending to detached for use as!	Physicia	past 12 months?		nant at time of o	death 5	Other (Spe	ecify)						
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P.O. es that the general by oe detach	by P	Part II. Other significant condition	ons contributing t	o death but not	resulting in t	he underlyin	g cause giv	ven in Pa	rt I.				to the cause of death?
D, P													robably 4 V Unknown
v requ	Completed				_					24a. Was auto	psy	prior to	autopsy findings available o completion of cause of
ecc he lav ite ha	틹		-		-						ormed?	death? 1 ✔	
rtifice		25. Was case referred to medical	Т				26.Place	of Death ((Check on	ly one)	19000		
/ita	o Be	examiner? 1. ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpat	ient 3	DOA C	Other 4	Nursing	Home 5	Residence	e 6 🗸 Oth	her: Scene
Division of Vital Records, also Attending Physician: The law requires after death all Director: After this certificate has been sifed in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	\vdash	27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time	of Injury	28c. Injury	at Work	? 2	8d. Describe	how injury	occurred	
on ath be fu	흕	1 X Natural 5 Pendi	ng	i, Day, real)			1 Y	es 2	No				
r Atte	<u>i</u>		not be 28e. Place	ce of Injury - At	home, farm,	street, factor	y, office bu	ilding, et	c. 2			Number or I	Rural Route Number, City
Division spital or Attend ours after death neral Director: filled in by the	Certification:	Suicide 6 Could 4 Homicide detern								or Town,	State)		
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		00- 0-400-	sician: To the be	st of my knowle	edge, death o	ccurred at th	e time, dat	e and pla	ice, and di	ue to the cau	se(s) and r	nanner as st	tated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam	iner:On the basis and manner:	of examination	and/or inves	tigation, in m	y opinion,	death oc	curred at t	he time, date	and place	, and due to	the cause(s)
F 3 F 8	Me	29b. Signature and title of certifier				29	c. License	number			29d. Da	te signed (A	Month, Day, Year)
		1/1	y Kin	10		<u>ا</u> ر	O.C.N	1.E.	OCM	E	March	1, 2009	
		30. Name and address of person v	vho completed cab	se of death (Ite	em 23a)						J		
		Theodore M. King, Jr.,		ant Medical		111 P	enn Stre	eet, Bal	Itimore,	MD 2120	1		
	ate	31. Date filed (Month, Day, Year) MAR 0 5	0000 32.	egistrar's Signa	ature	and I	,						
Regist	rar	MARUS	ZUUY LA	were.	19.19	-							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lovester Lillian Rogers 02h-18-2009 Year 11:550 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mitchellville Villa Rosa Nursing Home Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 10-02-1912 Birthplace (State or Foreign Country)
 NC **Funeral** 1 □ M 2**X** F Months Days Hours 96 Director <u> 228-20-4733</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be notified at 10d. Inside City Limits PG Upper Marlboro MD Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 2400 Dorchester Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 SpecifyBlack 1 □Yes 2 No <u>\$</u> Specify. 3 ₩idowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 6th College (1-4or 5+) Private Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fil Department of Health and Mental I Important: If item 27 is marked ot any linyry or other traumatic ever once. Pages 1 and 2 should be in nent of Health and Mental Thomas Vinson ပ Katie Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Baldwin/Daughter 2400 Dorchester Rd. Upper Marlbro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Ceme. 02-28-09 Washington, dc 21. Signatu of Juneral Service Licenses 22. Name and Address of FacilitRonald Taylor II Funeral Hm. 10583 Middleport ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due (or as a consequence of): Cardio VanCu disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗆 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 1 ☐Yes 2 ZNo 5 ☐ Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral D e Funeral D letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Rakesh Arora, 14300 Gallant Fox Lane, Suite 222 Bowie, Md. 20715 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 2 5 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:35P M FEB. 2009 Dawn Larrimore Ruark 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 205 Vesper Avenue Social Security Number 6. Sex Federalsburg Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 27, 1 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖫 F 34 Yrs. **Director** 219-04-1718 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f short the Wolcal Examination at Director MDXXYes 2 □ No Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Vesper Avenue 21632 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 72 hours after 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 than "natural", or 1 ☐Yes 2 XNo Specify White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 should be filed within and Mental Hygiene. College (1-4or 5+) Own Home Homemaker is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic evance. Robert D. Larrimore Joan Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Ruark, Jr./Spouse 205 Vesper Avenue, <u>Federalsburg, MD 21632</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 09/09 Hillcrest Cem. Federalsburg, MD 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Framptom Funeral Home 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastanc Tonque 5 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Month 5 Other (specify) been signed by the should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 🗆 No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Halverson MD 8221 Teal Dr. Suite 302, Easton, MD 21601 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20, 2009 Grant James Smith 6:42 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea. Sept. 18, Suburban Hospital Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 2^{Year)}1924 Months 1 X M 2 □ F Michigan Yrs. 579-26-6586 84 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 Halsey Street 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 Ano Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Real Estate Mgmt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Gaston Smith Lillian Gillon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 Halsey Street, Kensington, MD 20895 19a. Informant's Name/Relationship (Type. Print) Akabe B. Smith/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Feb. 27, XX Burial 2 Cremation 3 Removal from State Holy Ghost Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Issue, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Kyphoscoliosis years Due to or as a consequence of Post-Polio Syndrome years Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? babiy 4 ☐ Unknown

Physician /Medical Examiner

burial-transi

director, page 2 should

Be

Certification: To

Medical

has

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

the death certificate be executed

68760, :42

Box

P.O.

Records,

Division of Vital

N

TAMES

Physician

/Medical

Examiner

Funeral

Director

r Items 23a or 28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural"; o any injury or other traumatic event, the Medical Exemples.

death with

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown ₹ Completed

Seizure Disorder

. Were auto prior to co death?

ppsy findings available empletion of cause of 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2√€No 27. Manner of Death 1 Natural 5 Pending

2 Accident

3 🗌 Suicide

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) investigation 6 Could not be determined

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number D63136

29d. Date signed (Month, Day, Year) February 21, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard T. Mahon, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) FEB 2 3 2009

State Registrar Registrar's Signature rached

			1 - For State Registra AMEND#8perFH2	State of Ma 23/09.BWV.Mc			rtment of l		d Mental	Hygier Reg. 1		9	07498
ı	Physici /Medio		1. Decedent's Name (First, Middle, Le COLLEEN R.					-	2. Date o Month Febr	f Death	Day7,2009	ar	3. Time of Death 3:30 P M
1	Examir		4a. Facility Name (If not institution, given Shady Grove Adve	ntist Hosp			4b. City, Town, o	ille	eath	4	4c. County of D	eath	у
ı	Funeral Director		5. Social Security Number 213–40–8571 Usual Residence of Decedent	Sex 7. Age	(In yrs. last	Yrs.	If Under 1 Year Months Days		Hrs. 8. Date o (Month)	f Birth I, Day, Yea 20,	1940 ^{9.} 1949]	Count	ace (State or Foreign ry) .ana
	e Maryland 3a-f show	Director	10a. State 10b. County MD Montgon	ery	10c. City, T	own or Loc						10	d. Inside City Limits 1
	th with th	ral Dire	10e. Street and Number 1310 Grandin Ave	nue			10f. Zip Code	0851			Citizen of What		,
5-0036	'natural", or items 23a or 28a-f show	by Funeral	11. Marital Status 1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:			Vas Decedent of F Yes, specify Cuba ☐ Yes 2 X No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes o Jerto Rican, etc.	r No-	14. Race - A Black, W Specify:	hite, et	C.
0-61212	within ene.	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	. 1	(Give I life. D	ent's Usual Occup kind of work done DO NOT use retired al Record	during most of (d)	working ialist	1	Kind of Busine	ess/Indu	stry
Maryland	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, <u>E</u>	To Be C	17. Father's Name (First, Middle, Last Thomas E. Flynn)					Name (First, Mide		,		
, Mar	and 2 sho ealth and ; n 27 is me er traums		19a. Informant's Name/Relationship (Robert S. Schweng		ıd)	1310	g Address <i>(Street</i> Grandin	Ave. Ro				e, Zip (Code)
Baitimore,	t. Pages 1 tment of H tant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y)	20b. Place ceme Gate	of H	eltion (Name of atory or other place eaven Ce	m. 2	b. 23,	1	Location - City		•
Ra	permit Depar Impor any in		21. Signature of Funeral Service Licer	lay		10	Name and Addre	eer Parl		ithe		MD	20877
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plication that caused to one cause on each line a. Stroke M Due to (or as a	Multip	le	r the mode of dyir	ng, such as card	diac or respirato	ry arrest,		- (Approximate Interval Between Onset and Death Days
8/60,	ficate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a			-						
. O. Box 68/	ath certi attending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	d	☐ Fetal dea	ath 3 🗌	Ectopic pregnanc Other (specify)	у		_	23d. Date of o		ay Year
ecords, P	quires that the de en signed by the a uld be detached t	þ	Part II. Other significant conditions of	ontributing to death but	not resulting	g in the uno	derlying cause give	en in Part I.	111				cause of death?
vitai neco	n: The law requii ficate has been s r, page 2 should	Completed							24a. W an pr 1 🔀 Ye	utopsy erformed?	prior t death	to comp	y findings available eletion of cause of
	ding Physician: The h. h. After this certificate h. funeral director, page	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 X Inpatient				er: 4 🗆 Nursing	Death (Check on Home 5 R	esidence		pecify)	
UNISION	l or Attending after death. Director: After I in by the funer	Certification: T	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		Year) y - At home,	o. Time of Injury farm, stree		y at (? Yes 2 □ No	28f. Locatio		ury occurred and Number or te)	Rural F	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of hiner: On the basis of e and manner state	examination	dge, death and/or inve	occurred at the tirestigation, in my o	ne, date and pla pinion, death or	ace, and due to ccurred at the tir	the cause ne, date a	(s) and manner nd place, and d	as stat	red. ne cause(s)
)	# Nathing Somp	Me	29b. Signature and title of certifier July 1				29c. License				eate signed (Mo		
			30. Name and address of person who Dr. Sireesha Jal	li M.D. 9	9901 M	ledica	1 Center	Dr. Ro	ockville	, MD	20850		
	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 23 20	3 Registrar's	s Signature	par	40						

Funeral **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Der artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invarious by notified at once. Baltimore, Maryland 21215-0036

Physicia /Medic Examin

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, 🤛 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10+1

1 - For State Registrar	te of Maryland		artment of H			ene2 () (19 07499	
Decedent's Name (First, Middle, Last)	-				2. Date of Death		3. Time of Death	
THEO DORE JOS	SEPH	STAI	154		Month Februar	y 22, 2	Year 009 4:20 a M	
4a. Facility Name (If not institution, give street a		- \	4b. City, Town, or	Location of Death		4c. County of		
Shady Grove Adventi	st Hospital	1	Rock	ville		М	lontgomery	
Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Voar)	9. Birthplace (State or Foreign	
165-22-2002	[□] F 82	Yrs.	Worters Days	nours Iviin.	8. Date of Birth (Month, Day, June 19	, 1926	Pennsylvania	
Usual Residence of Decedent	140.00	T						
10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits 1 X Yes 2 ☐ No	
Maryland Montgomery Rockville 0e. Street and Number 10f. Zip Code 10g. Citizen of What Co								
10e. Street and Number	nat Country?							
5923 Holland Road	2085			USA				
							- American Indian, White, etc.	
If Ye	Yes 2∏No es, Give WWII	1	□Yes 21X1No	Specify:		Specify:	White	
	r or Dates: WWII					1 ' '		
15. Decedent's Education (Specify only highest grade comp	eted)	(Give I	lent's Usual Occupa kind of work done di	tion <i>iring most of work</i>	ing	6b. Kind of Busi	iness/Industry	
Elementary/Secondary (0-12) Coll	ege (1-4or 5+)		OO NOT use retired)	70 700°	tant	Fo30	1 Government	
17. Father's Name (First, Middle, Last)		Admi	nistrativ		e (First, Middle, Ma			
Thomas Stavish					ine Wolf	,	,	
	41	105 10	- Add (C					
19a. Informant's Name/Relationship (Type. Prin. Mary Margaret Stavis	· .		g Address (Street a					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cer	metery, crem	sition (Name of natory or other place) F	eb. 26,		ity or Town, State	
21. Signature of Funeral Service Licensee	Gate		leaven Cer		2009		Spring, Maryla	
Muan Gul	lee		Pancis Address				nc. Spring, MD 20	
23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	that caused the death. on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death	
disease or condition a. Se	psis						days	
	ue to (or as a conseque	as a consequence of): ation Pneumonia						
Sequentially list conditions D.	ue to (or as a conseque		ita				days	
Cause. Enter Underlying Cause (Disease or injury	inal Cord (-	ecion wit	h Daralı	reic of To	wan Evt	remities wee	
that initiated events c. PP	ue to (or as a conseque		SSIUI WI	II Farary	SIS OL LO	Mel TYC	Temitites wee	
Mu	ltiple Mye	loma					years	
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in the past 12 months?	s, outcome of pregnand Live birth 2☐ Fetal d Pregnant at time of dea Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Monti		
Part II. Other significant conditions contributing	to death but not resulti	ing in the un	derlying cause giver	in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?	
			-				☐ Probably 4☐ Unknown	
					24a. Was an autopsy performe	24b. We prid	ere autopsy findings available or to completion of cause of ath?	
25. Was case referred to medical				26 Plans of D: "		±No 1□	☐Yes 2☐No	
examiner? 1 Yes 2 XNo Hospital:	1 X Inpatient 2 ☐ El	D/Outrotio-	Othor		(Check only one)			
	Date of Injury 2	R/Outpatient 8b. Time of	28c. Injury	4 Li Nuising 110	me 5 Residence 28d. Describe how			
1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work?	es 2 🗆 No	_sa. Describe now	ngary occurred		
a Could not be	Place of Injury - At hom building, etc. <i>(Sp</i> ec <i>ify)</i>	e, farm, stre			28f. Location (Stre City or Town,	et a <i>nd Number</i> State)	or Rural Route Number,	
29a. Certifier (Check only one) 1	To the best of my knowlethe basis of examination	edge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, nion, death occurr	and due to the cau red at the time, date	ise(s) and mani e and place, an	ner as stated. d due to the cause(s)	
29b. Signature and title of certifler	1		29c. License	number	290	l. Date signed (Month, Day, Year)	
30. Name and address of person who completed	Cause of death (Item 2	23a) (Type P	120065 Print)	830	Fe	born	22,2009	
JAMIE 1. MOR	ano, mo	9901	MEDICAL (ENTER DI	, ROCKU	ile mo		
34. Date filed (Month, Day, Year) FER 2 4 2009	32 Registrar's Signatur	re	-A A					
	Vienn B.	TO CA	No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stat Registra

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 20, 2009 **Physician** Satterfield 18:43 PM Cristina G. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth Feb. 28, 1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 👽 F 69 Bolivia 217-72-2823 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It of Pedicol Examination to multiple at Yos 2 □ No Maryland Prince George's College Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20740 United States 5924 Westchester Park Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 YEYes 2□No Specify: Bolivian Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 th and Mental Hygiene... 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Franklin Godov Margarita Morales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau David J. Satterfield -husband 5924 Westchester Park Drive College Park, Md. 20740 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Metropolitan Crematory 2/26/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disseminated Lung Cancer Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burial-tran Due to (or as a consequence of): physician a Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day 5 Other (specify) signed by the a d be detached for Ö 9 Unknown ₽. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2X No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) and the of certifie 29b. Signature D68150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Glen Rd. Silver Spring, Wo 1500 31. Date filed (Month; Day, Year) State

Registrar